

Evaluation of The California Child Abuse Treatment Program

Final Report of
The California State University,
Long Beach



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Evaluation, Monitoring and
Audits Division

Governor's Office of Criminal Justice Planning

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Arnold Schwarzenegger
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**CHILD ABUSE TREATMENT (CHAT) PROGRAM
FINAL EVALUATION REPORT**

**Governor's Office of Criminal Justice Planning (OCJP)
Sacramento, California**

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Submitted by

Carrie J. Petrucci, Ph.D.

California State University Long Beach

Dept. of Social Work

1250 Bellflower Blvd.

Long Beach, CA 90840-4602

cpetrucc@csulb.edu

Telephone: (562) 985-5658

Fax: (562) 985-9035

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EXECUTIVE SUMMARY

Background

The Child Abuse Treatment (CHAT) Program began in October of 2000 with 18 funded agencies. The purpose of the CHAT program was to fund direct services to child victims of abuse and neglect in counties which were currently not funded or inadequately funded. Non-offending family members were also eligible to receive services. Comprehensive treatment services included outreach, intake, assessment, individual, family and group counseling, court-related services, out-of-home placement, and follow-up evaluation. In October of 2001, an additional 27 agencies were funded, for a total of 45 CHAT-funded agencies. Funding was continued in October of 2002 and October 2003 for these 45 agencies.

Methodology

A prospective cohort design was used that tracked all new child victims coming into all CHAT programs from January to June 2002. Standardized pretests and posttests that included a 6-month follow-up were administered. Data collection also included analysis of all 2001/2002 Annual Progress Reports submitted by each agency. For 18 of the agencies, this was their second year of CHAT service provision. For the remaining 27 agencies, it was their first year of CHAT service provision.

Standardized assessment instruments incorporated by all agencies included: the Children's Global Assessment Scale (CGAS), the Global Assessment of Relational Functioning (GARF), the Columbia Impairment Scale (CIS), the Child Behavior Checklist (CBCL); and the Youth Self Report (YSR). In addition, 9 questions on parenting were developed by therapists specifically for this evaluation. Additional information was collected from therapists on child demographics, CHAT services provided, outcome of therapy services, various areas of functioning of the child and the non-offending parent, and types of abuse experienced by the child.

Were the Program Objectives Achieved?

The CHAT program had 4 primary objectives, each of which was met by most CHAT agencies. The program objectives were:

- *To provide treatment services to child victims of abuse and their non-offending family members*

Over 7,000 children received treatment services in 2001/2002, which was 48% more than projected. Seventy-eight percent of agencies (34) surpassed their direct services provision. Over 50,000 service contacts were made statewide with CHAT clients.

- *To assist the child victim and their non-offending family members in filing for victim compensation services.*

Almost 3,400 children received assistance in filing for victim compensation. This was 9% below projections. Fifty-two percent of agencies met or exceeded their projections for assisting victims. Common reasons given for being unable to meet projections included the family's reluctance to file a crime report, which is a requirement for filing.

- *To provide criminal justice advocacy services to child abuse victims who were participating in criminal justice proceedings.*

Over 3,900 children received criminal justice advocacy services. This was 89% above stated objectives. Sixty-four percent of agencies met or exceeded their criminal justice advocacy projections.

- *To use trained volunteers in the provision of appropriate support services.*

Agencies exceeded projections by 11% for full-time equivalency of use of volunteers, but fell 11% below projected goals for volunteer training. Sixty-nine percent of agencies exceeded their stated objectives for volunteer FTE's, 13% did not utilize volunteers and 17% fell short of their stated goal. Sixty-percent of agencies met or exceeded their goal for volunteer training, 22% fell below it and 18% did not train volunteers.

Were Grant Funds Spent Efficiently?

A functional budgeting perspective, focusing on service provision and total costs for 2001/2002, was carried out. Note should be made that this analysis is not intended as a detailed cost-effectiveness analysis, but is included rather to present a picture of the number of service outputs provided and the number of clients served and the associated costs.

The total cost of the CHAT program for 2001/2002 for the 45 CHAT agencies was \$9,167,842. An average cost of \$177 per service contact was computed by dividing the total cost by 51,916 service contacts. An average cost of \$860 per client was computed by dividing the cost by 10,656, the projected number of client contacts. Over 14,000 clients were actually served. Using the average cost per client, direct services was estimated to cost \$4.1 million; victim compensation was estimated to cost \$3.2 million, and criminal justice advocacy was estimated to cost \$1.8 million in 2001/2002.

Based on the above information, it was found that funds were spent efficiently. The projected number of clients (10,656) to be served was met and exceeded, with over 14,000 clients actually served, at a cost of \$860 per client for the same total dollar amount of \$9.1 million.

Was the Intended Problem Addressed?

This question was answered in three sections based primarily on the 6-month cohort data. Based on the pretest/posttest outcome measures and the analysis of non-

monetary benefits, most children and their families benefited from CHAT treatment services, indicating that the intended problem was addressed.

WHAT WERE THE CHARACTERISTICS OF CHILDREN IN THE CHAT PROGRAM?

- Witnessing domestic violence and emotional abuse occurred in more than 60% of the sample. These were the two most common types of abuse experienced by children.
- Twenty-nine percent of the sample experienced 1 type of abuse; 71% of the sample experienced 2 or more types of abuse.
- The largest category of other system involvement for children was child protective services now or in the past, which included 40% of children. The most common category for other system involvement by caregivers was being a victim of domestic violence (42%), followed by being a victim of physical abuse (25%), and being involved in drug or alcohol abuse (20%).
- Over half of the children (52%) were believed to have their school performance affected by the abuse, according to therapists. A second most common concern was substance abuse or alcohol abuse occurring in the home (40%). An open CPS case was indicated in 23% of children.
- Therapists noted school performance occurring as a major or persistent problem in 24% of children.
- Over 40% of children fell into a clinical category at intake based on the internalizing behaviors scale, externalizing behavior scale, and the total problems scale of the CBCL.
- Overall, based on the CBCL and the YSR, CHAT children fell between the referred and non-referred samples, scoring higher (more problems, less competencies) than the non-referred or healthy sample, but scoring lower (less problems, more competencies) than the referred or mental health sample.

HOW DID CHILDREN BENEFIT FROM CHAT SERVICES?

- Children's overall functioning as measured by the CGAS increased by 8%, going from an average score of 58 to an average score of 62, based on a sample of 502 children. However, 45% of children remained in the clinical range at 6-months, suggesting an ongoing need for treatment.
- Children's relational functioning as measured by the GARF increased by 7%, going from an average score of 59 to an average score of 63, based on a sample of 464 children.
- The total impairment or problem score (CIS) measuring interpersonal relations, broad psychopathology, school and work, and leisure time, decreased by 26%

(meaning less problems were noted), going from an average of 25 to an average of 19, based on a sample of 218 children. However, 62% of children remained in the clinical category at 6-months, suggesting the need for ongoing treatment.

- According to therapists, there was an 11% increase in parents/caregivers' abilities to talk about the abuse at 6-months than at intake. There was a 6% increase in parents/caregivers capabilities of setting reasonable limits for the child's acting out behaviors at 6-month follow-up than at intake.
- On average, children with 1 type of abuse had higher functioning at 6-months based on the CGAS, GARF and CIS than children with multiple types of abuse.

WHAT WERE THE NON-MONETARY BENEFITS TO CHILDREN IN WHICH CHAT SERVICES WERE PROVIDED?

A concept mapping approach, using multi-dimensional scaling and cluster analysis techniques was used to analyze 126 benefits to children documented by 34 agencies. Benefits were categorized into 10 areas based on how agency personnel sorted the 126 benefits. Clusters included benefits to children in the following areas: school-related, external behaviors, assistance to parents, accessing resources, relating to peers and in groups, therapy process, interactions with parent and family, internal functioning, skill development and symptoms related to the abusive event. This approach provides a validated list of potential outcomes for child abuse treatment based on expert opinion, and categorizes this list into 10 conceptual areas for future instrument development.

Did Program Elements Work?

Based on data presented in the progress reports, all program elements were found to have worked for most agencies. Use of volunteers and crime victim compensation were two program elements that were problematic for a small number of agencies.

What Lessons were Learned for Future Programs?

- A participatory or responsive evaluation procedure was carried out in order to complete the research-based goals of the evaluation. Agency buy-in is essential in carrying out an evaluation of this type. This was accomplished through a 6-month development phase that permitted inclusive decision-making on the assessment instruments to be utilized. Regional meetings were also conducted periodically at 6 locations throughout the state so that agency personnel could meet face-to-face with the evaluator to discuss the development and implementation of the evaluation. For future outcome evaluations in child abuse treatment, sufficient allocation of resources dedicated to evaluation is recommended to capture accurate data and document treatment outcomes.
- A 9-question reliable measure on parenting was developed out of one of these regional meetings that may be useful in practice and evaluation in the future.

- Accessing, training, and monitoring volunteers were problematic for a small number of agencies. Creative problem-solving is needed in community contexts in which volunteers are difficult to find.

Recommendations:

Recommendation 1: Multiple and co-occurring types of abuse should be the standard for documentation rather than forcing a choice of recording only one type of abuse per child.

Recommendation 2: The high-prevalence of the co-occurrence of child witnessing of domestic violence with other types of abuse as well as a high percentage of caregivers being victims of domestic violence suggests that the safety issues and treatment needs of domestic violence be integrated as a standard consideration in child abuse treatment programs.

Recommendation 3: Standardized assessment instruments at regular intervals that include intake and at least one follow-up should be incorporated into all future grant requirements for child abuse treatment programs. At a minimum, the CGAS could be incorporated by all funded agencies. The CIS is also a good potential instrument.

Recommendation 4: Particularly for English-speaking populations, the CBCL and the YSR are recommended as possible intake instruments for agencies with the resources to immediately score these instruments. Follow-up administrations at regular intervals are also recommended when possible. For Spanish-speaking populations, agencies should pursue reliability-checks to determine if the Spanish-language CBCL is appropriate.

Recommendation 5: Several outcomes of child abuse treatment were identified that can be integrated into future practice and evaluation of child abuse programs. To the extent that agencies can access it, attempts should be made to collect information on as many of these 10 areas as possible. Grant funders should consider incorporating incentives to agencies that successfully collaborate, particularly with schools, so that children's needs can be identified early and met on a preventive basis.

Recommendation 6: Based on their CBCL, CIS, and CGAS scores, a large percentage of children in the CHAT program were in need of therapeutic services at intake. In addition, program implementation appears to be cost-effective when considering an average cost per service. Ongoing funding should be pursued so that children in need can continue to access the continuum of services available in these child abuse treatment services agencies.

Recommendation 7: On average, children's post-test scores showed improvement over their pre-test scores in a 6-month follow-up. However, not all children will show improvement in the short-term. Longer-term follow-ups are needed to more accurately represent how children's functioning changes over time and to determine an adequate length of treatment.

BACKGROUND¹

Overview

The Child Abuse Treatment (CHAT) Program began in October of 2000 with 18 funded agencies. The purpose of the CHAT program was to fund direct services to child victims of abuse and neglect in counties which were currently not funded or inadequately funded. Non-offending family members were also eligible to receive services as an integral part of the child's treatment. In October of 2001, an additional 27 agencies were funded, for a total of 45 CHAT-funded agencies. Funding was continued in October of 2002 and October 2003 for these 45 agencies. CHAT programs were required to provide comprehensive treatment to child victims who had experienced:

- Physical abuse
- Sexual abuse and/or exploitation
- Emotional abuse
- Neglect
- Domestic violence
- Parental substance abuse and endangering life style (such as the environment in home-based clandestine methamphetamine labs)
- Child abduction by a stranger, family member, or acquaintance
- Child maltreatment and violence in the school or community, including hate crimes

Comprehensive treatment services included but were not limited to:

- Outreach
- Intake
- Assessment
- Individual, family, and group counseling
- Court-related services
- Out-of-home placement services
- Follow-up evaluation

Services were provided to child victims of abuse and violence under the age of eighteen (18), and their appropriate non-offending family members. A non-offending family member was defined as someone who did not commit the abusive or neglectful act on the child. Services were also to be provided to disabled child victims of abuse. Lastly, services needed to be provided in a culturally sensitive and appropriate manner.

Legislative Authority

The Victims of Crime Act (VOCA) of 1984, Public Law 98-473, as amended, 42 USC 10601 et seq. authorizes the use of federal funds for victim assistance. The source of revenue for this Act comes from the collection of fines and restitution levied under federal law against individuals and organizations convicted of federal crimes. The

¹ Material in this section was taken from the February 2001 *Program Guidelines* document for the CHAT Program, authored by the Children's Branch at the Governor's Office of Criminal Justice Planning.

Governor's Office of Criminal Justice Planning (OCJP) had State statutory authority over these funds, subject to their federal appropriation and annual approval in the State Budget Act.

Program Elements

The organizational requirements or program elements included the following:

- **Implementing Agencies:** All implementing agencies had to be either governmental, private non-profit organizations, or American Indian tribes/organizations in California. Agencies implementing the CHAT program were selected through a competitive Request for Proposal (RFP) process.
- **Funding Match Required:** Agencies implementing the CHAT program provided a certain level of matching funds which were calculated based on the total project cost as opposed to the "percent of allocation" method. The VOCA match could be met with cash or in-kind contributions based on the total project cost. Existing projects in operation for at least one year and new projects in operation for less than one year had a 20% match required. American Indian tribes or organizations had either a 5% or a 20% match required. To qualify for the 5% match requirement, American Indian tribes/organizations had to be physically located on a reservation or in the catchment area as defined by the Bureau of Indian Affairs. If the American Indian tribe/organization was located in an inner-city or in an urban area, a 20% match was required.
- **Direct Services:** Project grant funds had to be used for allowable direct services to victims of child abuse. For purposes of the CHAT program, this referred to activities which directly benefited individual child victims. VOCA allowable services included but were not limited to:
 - Crisis counseling
 - Follow-up counseling
 - Therapy
 - Group treatment/support
 - Emergency shelter/safehouse
 - Information/referral (in person and telephone)
 - Criminal justice support/advocacy
 - Emergency services (i.e., food, clothing, shelter, financial assistance, and legal advocacy)
 - Assistance filing for compensation claims
 - Personal advocacy

Activities unrelated to the provision of direct services to child victims were not allowable costs. VOCA funds could not be used for coordination efforts unless directly tied to direct services. Indirect or administrative costs were not permissible in VOCA funded victim assistance grants.

- **Use of Volunteers:** CHAT projects were required to use volunteers unless there was a compelling reason to waive this requirement.
- **Promote Community Efforts to Aid Crime Victims:** CHAT projects were required to promote coordinated public and private efforts to aid child victims within the community served. Because of the various kinds of services needed by child victims of crime, services were usually provided by a variety of agencies. Therefore, it was essential that these services were coordinated to ensure continuity of support to the victims, and to avoid duplication of effort. Although coordinating efforts qualified an organization to receive VOCA funds, these were not activities that could be supported with VOCA funds.
- **Crime Victim Compensation:** CHAT projects were required to assist child victims in seeking available crime victim compensation. Such assistance was achieved by identifying and notifying potential recipients of the availability of compensation, and assisting them with application forms and procedures. However, once clients became eligible to receive state witness compensation funding for counseling, the client was no longer eligible for CHAT-funded counseling, but could receive other CHAT services. An eligible program must demonstrate that it referred clients to the State Victim/Witness Assistance Programs. Grant funded project personnel were prohibited from requesting remuneration via the State Victim Compensation Program for services rendered in accordance with the project's grant award agreement.
- **Provide Services to Child Victims with Disabilities:** CHAT projects were required to be in compliance with the Americans with Disabilities Act (ADA) of 1990, 42 U.S.C. 12101, et seq, and Title 28 of the Code of Federal Regulations, part 35.
- **Other:** All projects must adhere to additional State and federal requirements, such as maintaining civil rights information, and confidentiality of client-counselor information.

Program Objectives

The CHAT program had four primary objectives:

- **To provide treatment services to child victims of abuse and their non-offending family members**

Projects were required to provide intensive therapeutic services by a licensed clinician for child victims. All services to the nonoffending family members were provided strictly to enhance the therapeutic needs of the child clients, and not to address the nonoffending family members' own victimization issues. Treatment modalities included individual and group counseling separately or in combination.

- **To assist the child victim and their non-offending family members in filing for victim compensation services**

Projects were required to assist child victims and their non-offending family members in filing for victim compensation services. Such assistance could include, but was not limited to, any one of the following:

- Identifying and notifying potential recipients of the availability of Victim/Witness compensation
- Assisting with application forms, procedures, and follow-up on claim status

The CHAT project was required to work cooperatively with county Victim/Witness Centers in meeting this objective.

- **To provide criminal justice advocacy services to child abuse victims who were participating in criminal justice proceedings**

The CHAT project was required to provide court related services to assist child abuse victims who are participating in criminal justice proceedings. The project advised the clients of the types of court related services available. These included, but were not limited to any one or more of the following:

- Transportation to court
- Escort services
- The filing of child abuse petitions
- Temporary restraining orders
- Explaining court procedures
- Accompanying the child victim to court during a trial
- Post-sentencing services and support

- **To use trained volunteers in the provision of appropriate support services**

CHAT projects were required to use volunteers in the execution of the project. However, volunteers could not have contact with children and their non-offending families until the following criteria was met:

1. A formal application including three references checked by program staff was completed;
2. A criminal records check which included fingerprinting and processing through the Department of Justice was completed;
3. A child abuse index check was required if the agency was mandated by law to complete this check, or if the agency had a policy in place requiring such a check.

4. A Department of Motor Vehicles records check was required for staff who transported child abuse treatment clients.
5. Volunteers who did not have documentation of up to two (2) years of experience or training in working with child abuse victims had to complete a minimum of 40 hours of formalized training prior to any contact with children and families. This training included, but was not limited to, the following: crisis intervention; assessment and treatment issues related to neglect, abuse, domestic violence; assessment of substance abuse and family dynamics; issues related to child abduction; cultural awareness and sensitivity related to special needs populations and ethnic minorities; child abuse reporting law and procedures; sexual abuse of children; psychological maltreatment; psychotherapeutic models for abused children; and treating abused adolescents.
6. Adequate supervision by a professional staff with expertise in the delivery of direct services to child victims was required.

Volunteers were not permitted to provide or engage in any direct face-to-face services with clients until the above requirements were met.

CHAT Agencies

The CHAT grant commenced in October 2000 and has been funded for an additional three years. In October 2000, 18 agencies were funded. In October 2001, an additional 27 agencies were funded for a total of 45 agencies. These 45 agencies were funded in October 2002 and October 2003. The focus of this evaluation is 2001/2002.

Funding

Annual funding for all CHAT projects was approximately \$5 million for the first year, and \$10 million each for the 2nd – 4th years of the grant cycle, for a total of \$35 million.

METHODOLOGY

This evaluation utilized multiple methods that incorporated both quantitative and qualitative data collection and analysis techniques. Forty-five CHAT agencies participated in the evaluation, based on data from the 2001/2002 funding year. This was the first year of funding for 27 of the agencies and the second year of funding for 18 agencies. See **Appendix A** for a list of these 45 CHAT agencies.

Purpose

The purpose of this evaluation was to determine the following:

- Were grant objectives achieved?
- Were grant funds spent efficiently?
- Was the intended problem addressed?

- ◆ What were the characteristics of children receiving CHAT services?
- ◆ How did children benefit from treatment?
- ◆ What were the non-monetary benefits to children, families, and communities in which CHAT services were provided?
- Did program elements work?
- What lessons were learned for future programs?

The two primary research purposes of this evaluation, discussed within the section that determined whether the intended problem was addressed, were:

- to provide an in-depth description of the characteristics of the statewide population of children receiving CHAT services, and
- to determine how children benefited from treatment.

Research Design and Data Collection

To determine if *grant objectives were achieved*, data was gathered from annual progress reports submitted by each agency.

To determine if *grant funds were spent efficiently*, a functional budget analysis that compared total dollars spent and total service units produced was conducted. The data utilized for this analysis included annual progress report data plus budget data made available by OCJP.

To determine if the *intended problem was addressed*, an in-depth description of the children was accomplished by collecting data from a 6-month cohort of all new CHAT clients receiving therapy services. Therapists provided data on:

- Child demographics
- CHAT services provided
- Outcome of therapy services
- Various areas of functioning of the child and the non-offending parent, and
- Types of abuse experienced

The above data was collected through the use of 2 forms developed for this evaluation: the *Core Package* and the *Child Specific Service Level Data Form*. Both are included in **Appendix B**. The *Core Package* contained the pretest and post-test outcome instruments (explained below), 17 questions addressing various areas of functioning of the child and family, and 18 questions on the child's abuse history. The *Child Specific Service Level Data Form* contained 9 questions on the child's demographics and 15 questions on the CHAT services provided to the child.

Sample sizes of available descriptive data varied by instrument, with 1,243 children comprising the largest sample size based on the *Core Package* data.

To learn how children benefited from treatment, a prospective cohort design with the use of pretest/posttests that included a 6-month follow-up was utilized. This resulted in a one-year data collection period that began between January and March 2002 and ended between January and March 2003 (agencies varied on their start/end dates).

Standardized outcome measures included:

- Children's Global Assessment Scale (CGAS)
- Global Assessment of Relational Functioning (GARF)
- Columbia Impairment Scale (CIS)
- Child Behavior Checklist (CBCL), and
- Youth Self Report (YSR)
- In addition, 9 questions on parenting were developed in concert with CHAT therapists and were asked on a pretest/post-test basis.

The CGAS, GARF, and CIS are public domain instruments and can be used at no cost. The 9 parenting questions were developed specifically for this evaluation. All were included in the *Core Package*. The CBCL and YSR are copyrighted instruments and were purchased by each agency.

Final pretest/posttest sample sizes varied by instrument, from as low as 218 for the CIS pretest/posttest to as high as 502 for the CGAS pretest/posttest. Various sample sizes are included in the analyses in order to make use of the greatest amount of data. Reliability analyses were performed on all instruments and are included in **Appendix C**.

To analyze non-monetary benefits to children, therapists completed the *Benefits Form*, developed for this evaluation and included in **Appendix B**. A concept mapping approach was then carried out, as outlined by William Trochim at Cornell University. This approach takes open-ended responses to a question from a group of experts and groups the responses using quantitative data analysis techniques (multidimensional scaling followed by a cluster analysis). One experienced therapist at 34 of the 43 CHAT agencies responded to the question: "How do children benefit from CHAT treatment services?". Responses were then subjected to the concept mapping analysis.

The analysis of benefits from a quantitative and qualitative approach as outlined above combined to produce a list of expected outcomes for children receiving child abuse treatment services.

Benefits to parents, families and the community as identified by therapists were also collected from the *Benefits Form*. However, the time-consuming nature of the concept mapping strategy did not allow these to be subjected to the concept mapping technique, so these areas are not discussed in this report.

Data collection also included site visits by the evaluator to more than half of the 43 agencies.

To determine *if program elements worked*, data from the annual progress reports submitted by each agency was analyzed. This data was supplemented with data collected from the 6-month cohort of new CHAT clients.

Finally, *lessons learned* for other agencies was another purpose of this evaluation. These were produced based on all available data, site visits, and the evaluator's overall experience in the 2-year evaluation process.

FINDINGS

Were Grant Objectives Achieved?

The CHAT program had 4 primary objectives:

- To provide direct services to child victims of abuse
- To assist the victim in filing for victim compensation services when possible
- To provide criminal justice advocacy
- To use volunteers in provision of appropriate support services.

Data for this section is reported based on progress report data from October 2001 to September 30, 2002 from the 45 grantee agencies. This data was utilized because it was the most recent complete data available at the time of the writing of this report.

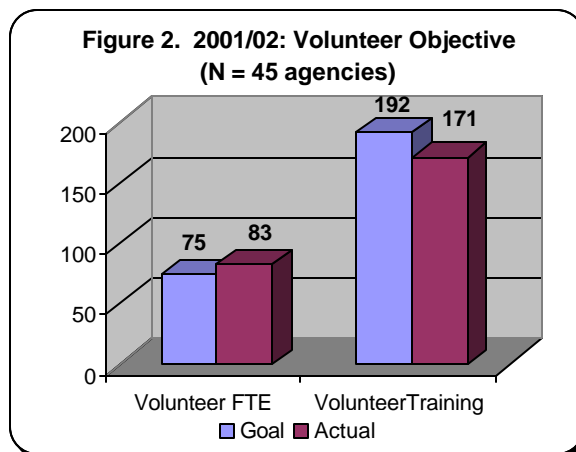
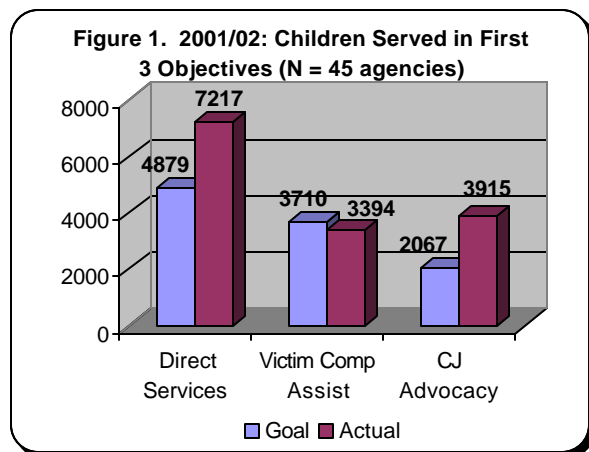
The 2001/2002 progress report data revealed that as a group, agencies met or exceeded all three of the four primary objectives.

- In the case of *direct services* and *criminal justice advocacy*, projected goals were exceeded.
- In the case of *assistance with filing victim compensation*, actual services provided were 9% below the aggregated victim compensation stated goals.
- *Volunteer FTE's* exceeded the projected goal while *volunteer training* came in 11% lower than anticipated.

The first 3 objectives are shown in **Figure 1**. The 4th objective is displayed in **Figure 2**.

Objective 1: Did CHAT programs reach projected goals to provide direct services to child victims of abuse? Yes.

- Over 7,000 children received treatment services from October 2001 to September 2002 across all agencies statewide (see **Figure 1**).
- This is 48% more than the total number of children projected to receive services.
- Seventy-eight percent of agencies (34) surpassed their direct services projection.



- Over 50,000 service contacts were made statewide with CHAT clients. This included a variety of services. Types of services and number of contacts for all 45 agencies during the one-year period of the grant are shown in Figure 3.
- Almost half of all service contacts were comprised of therapy (16%), telephone contacts (15%), and follow-up (14%), totaling 45% of all service contacts.
- Therapy services constituted the largest number of service contacts (8,376) for the year.
- This was followed by telephone contacts (7,842) and follow-up (7,494). Information and referral made up 10% (5,003) and crisis counseling made up 9% (4,865) of all service contacts across all agencies.
- Personal advocacy constituted 8% (3,928) of all service contacts.
- Group treatment made up 5% (2,576) of all service contacts, followed by shelter and support with 2% (1,049).
- Emergency legal advocacy constituted the smallest percentage of service contacts with 1% (544).

Objective 2: Did CHAT agencies reach stated goals to provide assistance in filing for victim's compensation? No. As a group, CHAT agencies fell 9% short of their goal.

- Almost 3,400 children received assistance in filing for victim's compensation (see **Figure 1**).
- This was 9% below the projected amount of 3,710.
- Fifty-two percent (23) of agencies met or exceeded their projections for assisting victims with filing for compensation, while 48% (22) of the agencies were unable to meet their projections.

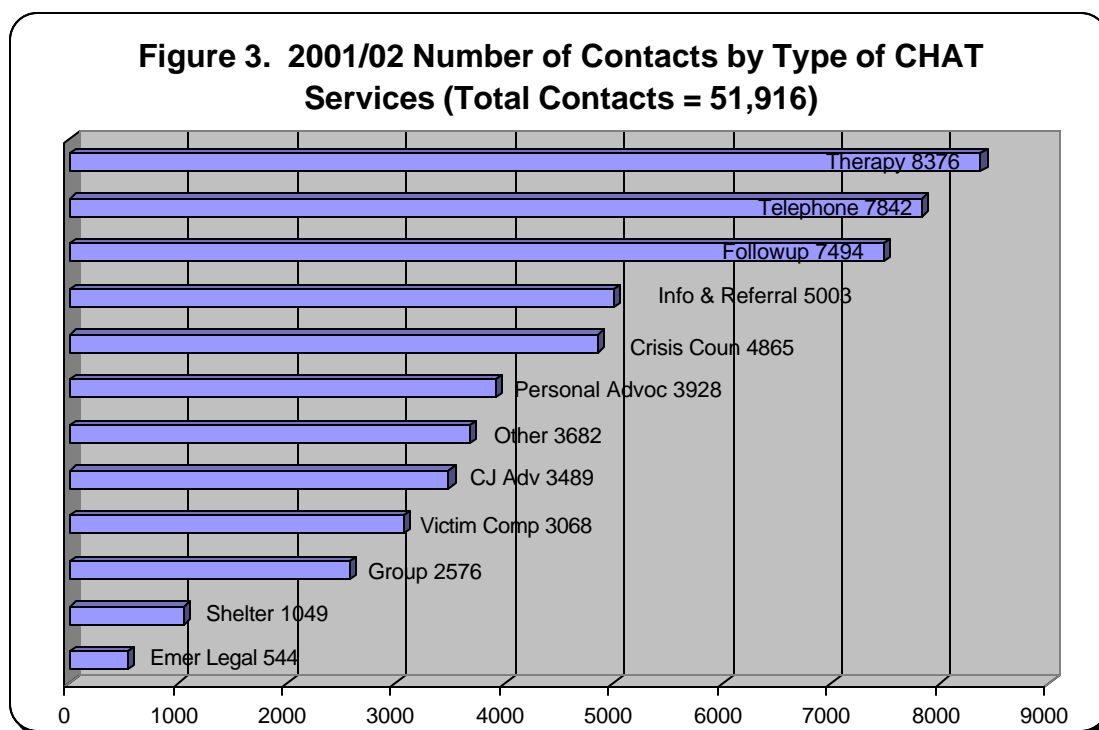
- Common reasons given for this centered around the family's reluctance to file a crime report, which is a requirement when filing for victim's compensation.
- Victim compensation assistance constituted 6% (3,068) of the service contacts (see **Figure 3**).

Objective 3: Did CHAT programs reach projected goals to provide criminal justice advocacy services to victims? Yes.

- Over 3,900 children received criminal justice advocacy services (see **Figure 1**).
- This was 89% above stated goals.
- Sixty-four percent (29) of agencies met or surpassed their criminal justice advocacy projections.
- Criminal justice advocacy (3,489) made up 7% of service contacts (see **Figure 3**).

Objective 4: Did CHAT agencies reach projected goals in using trained volunteers in the provision of appropriate support services? Yes, use of volunteers was above projections, however, volunteer training was 11% below projections.

- For use of volunteers, as a group, agencies exceeded projections for full-time equivalency (FTE) of use of volunteers by 11%, utilizing 83 FTE's for volunteers (see **Figure 2**).



- Sixty-nine percent of agencies (31) met or exceeded their stated goal for volunteer FTE's, 13% (6) did not utilize volunteers, and 17% (8) fell short of their goal.
- For volunteer training, agencies fell 11% below projected goals, with 171 volunteers trained during this one-year period with a goal of 192.
- Sixty percent of agencies (27) met or exceeded their goal for volunteer training, 22% (10) fell below their goal, and 18% (8) did not train volunteers at all (see **Figure 2**).

Were Grant Funds Spent Efficiently?

This discussion will focus on dollars spent during the 2001/2002 funding year of the CHAT grant because this was the most current data available. Individual agencies received project grants ranging from \$83,114 to \$443,848, with the average expenditures per agency at \$203,730. See **Appendix D** for the funding amounts received by each agency.

Efficient use of funds will be discussed from a *functional budgeting* perspective, which focuses on service provision, as explained below. Note should be made that this analysis is not intended as a detailed cost effectiveness analysis, as this is beyond the scope and resources of this evaluation. What is intended is to address whether funds were spent efficiently given the number of service outputs provided and the number of clients served.

Based on the analysis below, it was found that funds were spent efficiently. The projected number of clients to be served (10,656) was met and exceeded for the same dollar amount spent (\$9.1 million).

Functional Budget Approach. A functional budget approach¹ answers the following questions:

- How much service can a program provide in terms of its outputs, with outputs defined as products or services, quality outputs and/or service completions?
- What is the cost of a unit of service, a quality output, and/or a service completion?
- Based on the cost of outputs, what is the total cost of the program?

The procedure to carry out the functional budget approach involves the following steps:

- Determine the total cost of the program.²

¹ See Peter M. Kettner, Robert M. Moroney & Lawrence L. Martin's *Designing and Managing Programs: An Effectiveness-Based Approach*, 2nd edition (1999), at 197-203 (defines and explains functional program budgeting).

² Per Kettner et al. (1999), total costs includes both direct and indirect costs. However, because indirect costs were not permitted on the CHAT grant, for purposes of this analysis, only direct costs are included.

- Determine the program's output or service measures.
- Establish the program's desired output level on an annual basis.
- Compute the program's output costs by first determining the unit cost and then multiplying the unit cost by the total units of service provided.

To conduct this analysis, the following steps and assumptions were made:

1. The total dollars spent for the 2001/2002 funding year was \$9,167,842 across the 45 CHAT agencies. This figure is used as the *total cost of the program*.
2. *Unit of service* was selected because it could be determined from the data provided in the progress reports. Quality outputs and service completions would have required different data collection techniques and extensive coordination across the agencies and so are not analyzed here.
3. Given the variety of services provided in the CHAT program, there are several ways that *unit of service* can be defined. In order to capture the variety and magnitude of CHAT services, it was decided to use *service contacts* and *clients served* in two separate analyses in order to inform cost efficiency as much as possible.
4. No projections were available for *service contacts*, therefore, the actual number of service contacts (shown previously in **Figure 3**) was used to compute an average unit cost as follows:

$$\frac{\text{Total cost of program}}{\text{Total \# of service contacts}} = \frac{\$ 9,167,842}{51,916} = \$ 177 \text{ per service contact}$$

It should be remembered that amount of time per contact is not included in this analysis. Therefore, this unit cost is an average across all service contacts and does not reflect actual time spent.

5. For *clients served*, the projected number of child victims served was used for each of the 4 primary objectives (shown previously in **Figure 1**) to compute a unit cost as follows:

	<u>Projected (Goal)</u>
Direct Services:	4,879 children
Victim Compensation:	3,710 children
Criminal Justice Advocacy:	<u>2,067 children</u>

Total Projected Clients Served: 10,656 children

$$\frac{\text{Total cost of program}}{\text{Projected \# of client contacts}} = \frac{\$ 9,167,842}{10,656} = \$ 860 \text{ per client served}$$

The same caveat that was mentioned for *service contacts* should also be mentioned here. This per client figure does not take into account amount of time spent during each client contact. It is an *average* across all service contacts. Thus, in the case of the multiple sessions involved in direct services, this figure could be considered quite low. In the case of telephone contacts, however, this figure might seem quite high. More sophisticated analyses that consider the proportion of actual time spent could capture these differences, but are beyond the scope of this analysis.

6. *Total agency cost* in the case of *service contacts* can be informative when looking at comparative costs of various types of contacts, keeping in mind that the unit cost figure is an average (which is always a fictional amount) of all service contacts. For example, again referring to **Figure 3** shown previously, the following lists unit cost of *service contacts* across various types of services:

8,376 therapy contacts	X \$177 per service contact	=	\$ 1,482,552
7,842 telephone contacts	"	"	\$ 1,388,034
7,494 follow-up contacts	"	"	\$ 1,326,438
5,003 information & referral	"	"	\$ 885,531
4,865 crisis counseling	"	"	\$ 861,105
3,928 personal advocacy	"	"	\$ 695,256
3,682 other contacts	"	"	\$ 651,714
3,489 criminal justice advocacy	"	"	\$ 617,553
3,068 victim compensation	"	"	\$ 543,036
2,576 group counseling contacts	"	"	\$ 455,952
1,049 shelter contacts	"	"	\$ 185,673
544 emergency legal contacts	"	"	\$ 96,288
51,916 service contacts			

Total Program Cost: \$ 9,189,132³

7. *Total agency cost* in the case of *clients served* is computed as follows:

Total units of service (clients served) per Objective X Unit cost = Total Cost

<i>Direct Services</i>	4,879 clients	X	\$ 860 =	\$ 4,195,940
<i>Victim Compensation</i>	3,710 clients	X	\$ 860 =	\$ 3,190,600
<i>Criminal Justice Advocacy</i>	2,067 clients	X	\$ 860 =	\$ 1,777,620

Total Program Cost: 10,656 clients \$ 9,164,160³

Thus, the value in this approach is to determine the average cost of achieving specific objectives or outputs. It is apparent that in this case, the additional time required in direct services is better reflected in the figure above as a proportion of the total amount of services provided than it was in "therapy contacts" in item 6 above.

³ This figure is different from actual program cost due to rounding.

Finally, it should be remembered that in fact, 14,526 clients were served with the same dollar amount of \$9.1 million. This suggests at least two possibilities: agencies underestimated their projected goals, had funding to spare, and were therefore able to serve a greater number of clients; or, agencies underestimated their goals (or projected their goals accurately), but were forced to “do more with less” per client because they could not turn clients away. This analysis does not provide the necessary detailed information to answer this question, thus it would be without foundation to assume that one or the other is true.

Was the Intended Problem Addressed?

The CHAT program was designed to address the problem of child abuse treatment through increased availability of child abuse treatment services and continuity of care. To respond to the question of whether the intended problem was addressed, this section uses the 6-month cohort data to focus most specifically on direct services and how children benefited from those services. The *full baseline sample* refers to the 880 children who had a CBCL at intake in this 6-month period. A larger sample size of 1,248 children was utilized based on the number of Core Packages received at intake during this period. Three sections will be presented:

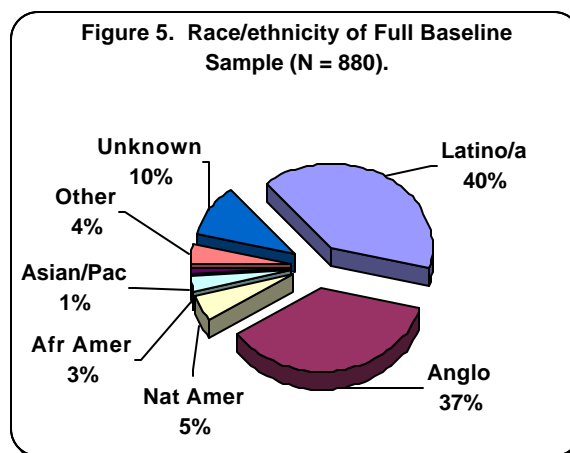
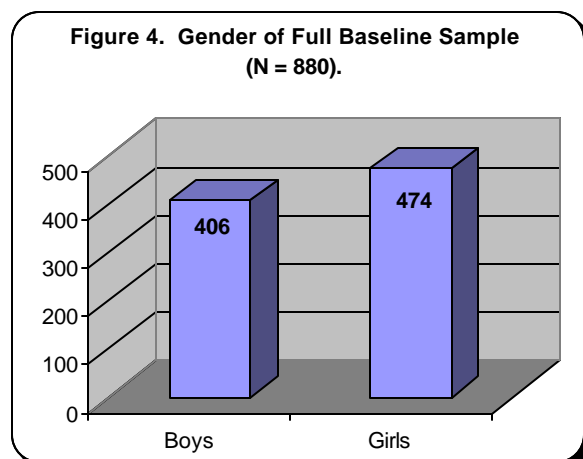
- What were the characteristics of children receiving CHAT services?
- How did children benefit from services?
- What were the non-monetary benefits to children, families, and communities?

The data described here suggests that, based on the pre-test/post-test outcome measures and analysis of the non-monetary benefits, most children and their families benefited from CHAT treatment services, indicating that the intended problem was addressed.

WHAT WERE THE CHARACTERISTICS OF CHILDREN IN THE CHAT PROGRAM?

Gender, race/ethnicity, and age. Demographic data were known for 880 children and are detailed in **Appendix E** and **Figures 4-6** below..

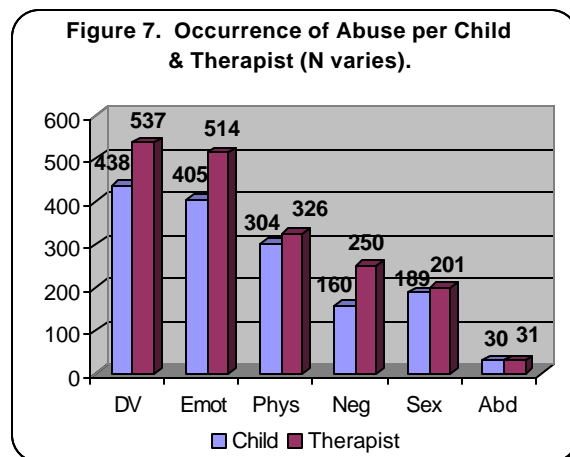
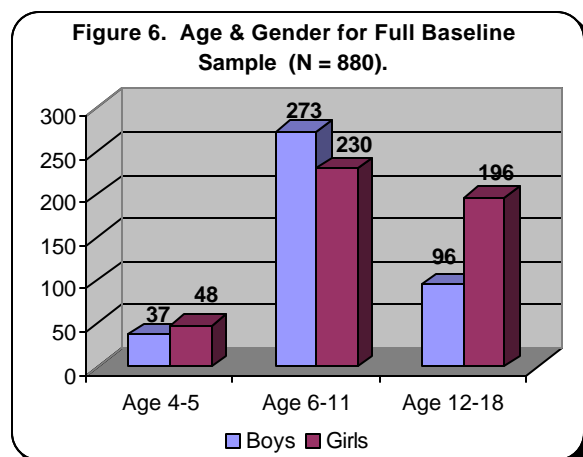
- The sample had more girls (54%) than boys (46%) (see **Figure 4**).



- The two largest racial/ethnic categories were Latino/a (40%) and Anglo (37%) (see **Figure 5**).
- Native American children made up 5% of the population (5 CHAT agencies specifically served Native American families).
- The remaining 18% of children was comprised of 3% African American, 1.4% Asian/Pacific Islander, 3.8% other, and 10% were children with unknown race/ethnicity.
- The age breakdown for both genders indicated the greatest percentage of children in the 6-11 year old range (57%) followed by 12-18 year olds (33%), and the smallest percentage of children being 4-5 years old (10%). The ranking of these 3 age groups was the same across both genders (see **Figure 6**).

Type of abuse. Type and severity of abuse was collected from both the therapist and the child. **Appendix F** and **Figure 7** below present a comparison of the child's reporting of types of abuse with the therapist's professional assessment of types of abuse experienced by the child. Correlates of abuse including peer pressure, community violence, and personal tragedy are also shown.

- Therapists' assessments involved a larger number of types of abuse experienced across all types of abuse than was identified by children. This is expected because children are less likely to identify their experiences as abuse in certain categories (emotional abuse, neglect, or witnessing domestic violence) unless they understand the behaviors that are defined as these types of abuse.
- The greatest differences between therapist and child assessments of type of abuse were seen in emotional abuse (11.7% difference), neglect (10% difference), and witnessing domestic violence (9.7%), with therapists assessing a higher level of abuse (see **Figure 7**).



- Differences were minimal in the case of physical abuse (2.2% difference), sexual abuse (1.1% difference), and abduction (less than 1% difference).

The ranking of the occurrence of types of abuse per therapist, going from most common to least common were:

- *Witnessing domestic violence and emotional abuse* occurred in more than 60% of the sample. These were the two most common types of abuse experienced by children, although it should be remembered that witnessing domestic violence is often considered a type of emotional abuse, so double-counting may have occurred.
- *Physical abuse* occurred in 40% of the sample.
- *Neglect* was identified in 30% of the sample.
- *Sexual abuse* occurred in about 25% of the sample.
- *Personal tragedy* was found in about 20% of the sample.
- *Peer pressure* was found in just under 15% of the sample.
- *Community violence* occurred in 13%.
- *Abduction* occurred in about 4% of the sample.

Total percents do not add up to 100% due to children experiencing more than one category of abuse.

Table 1 outlines the most commonly occurring types of abuse, with each child in only one category, so that these categories total to 100%. As is evident, types of abuse were extremely varied and most children experienced more than one type of abuse.

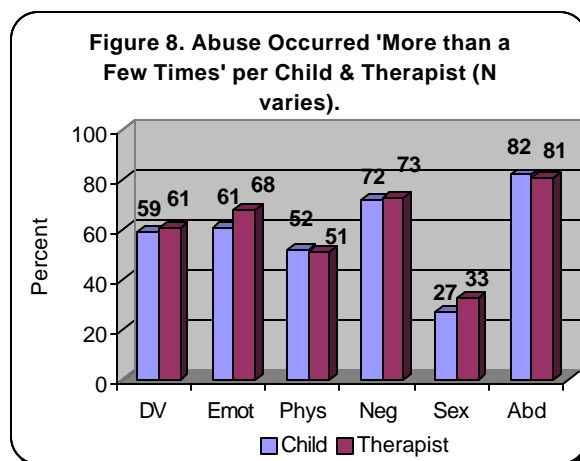
- The most commonly occurring type of abuse was *witnessing domestic violence* (13.2%).
- This was followed by a combination of *emotional, physical, and witnessing domestic violence* (13.1%).
- *Emotional abuse with witnessing domestic violence* (but without physical abuse) was the third most common type of abuse (12.7%).

Table 1. Most Commonly Occurring Types of Abuse (n = 789).

Type of abuse	n	%	Type of abuse	N	%
Witness DV	104	13.2%	Emotional	39	4.9%
Emotional Physical Witness DV	103	13.1%	Sexual Neglect Emotional Physical	29	3.7%
Emotional Witness DV	100	12.7%	Neglect Emotional	26	3.3%
Sexual	64	8.1%	Physical Witness DV	23	2.9%
Neglect Emotional Physical Witness DV	48	6.1%	Emotional Physical	22	2.8%
Subtotal:			603	76.4%	
Remaining cases:			186	23.6%	
Total Cases:			789	100%	

Severity of abuse. In the case of severity of abuse (how often abuse occurred), therapist assessments of severity were higher than the child's in 5 out of 9 types of abuse (see **Appendix F** and **Figure 8** below).

- Therapists assessed higher severity of abuse in cases of witnessing domestic violence, emotional, sexual, neglect, and peer pressure.
- Therapists were slightly lower in their assessments of severity than children in



physical abuse, abduction, community violence, and personal tragedy.

- The greatest difference in severity of abuse between the therapist and child was found in emotional abuse, in which therapists reported that the abuse occurred “more than a few times” on behalf of 7% more children.
- This was followed by sexual abuse (5.6% difference).

Differences in severity were smaller than in the overall counting of types of abuse. See **Appendix F** for details.

Table 2 and **Figure 9** outline the magnitude of types of abuse. It is notable that 29% of the sample experienced only *1 type of abuse* and the remaining 71% of the sample experienced *2 or more types of abuse*.

- Almost 30% of the sample experienced *2 types of abuse*.
- Just over 25% of the sample experienced *3 or more types of abuse*.
- Just over 15% of the sample experienced *4 or more types of abuse*.

Table 2. Magnitude of Abuse Types per Child (n = 789).

How many types of abuse per child	n	%	Cumulative %
1 only	232	29.4%	100%
2 types	217	27.5%	70.6%
3 types	210	26.6%	43.1%
4 or more types	130	16.5%	16.5%

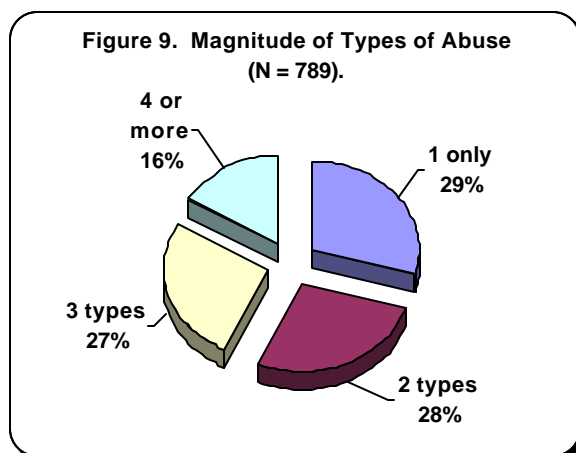


Table 3 breaks down type of abuse among those children who experienced *1 type of abuse*:

- *Witnessing domestic violence* made up the largest category with 13.2%. This was followed by:
- *Sexual abuse* (8.1%)
- *Emotional abuse* (not domestic violence) (4.9%), and
- Small percentages of *neglect* and *physical abuse*.

Table 3. Detail of One Type of Abuse (n = 789).

Type of abuse	n	%
Witness DV	104	13.2
Sexual	64	8.1
Emotional	39	4.9
Neglect	13	1.6
Physical	12	1.5
Subtotal	232	29.4
Multiple types	557	70.6

Other System Involvement for Child. **Table 4** outlines known prior agency involvement of children (N = 1,248), as indicated by therapists.

- The largest category was *child protective services (CPS)* involvement now or in the past, documented for 40% of children.
- The second largest category was *special education*, found in 10% of the sample.
- *Mental health or suicide attempts* was found in 5% of the sample.
- *Juvenile justice* involvement was found in 4% of the sample.

Other System Involvement for Child's Primary Caregiver. Also shown in **Table 4** is other system involvement now or in the past for the child's current primary caregiver.

- The largest category was the caregiver being a *victim of domestic violence*, occurring in 42% of the sample.
- This was followed by the caregiver being a *victim of physical abuse* (25%).
- Almost 20% of the sample had a caregiver involved in *drug/alcohol abuse*.
- *Extreme poverty* was indicated in 14% of the sample.

- For 12% of the sample, the caregiver was a *victim of sexual abuse*.
- *Chronic physical illness* was indicated in 10% of the caregivers.
- *Law violations, mental illness, psychiatric hospitalizations, and suicide attempts* each occurred in less than 10% of the sample.

Table 4. Other System Involvement of Child and Caregiver per Therapist (N = 1,248).

<i>To your knowledge, what agencies has the child been involved with now or in the past...</i>	Child	
	"Yes" response per therapist n	%
CPS	495	39.7
Special education	127	10.2
County mental health/suicide attempts	60	4.8
Juvenile justice	54	4.3
Psychiatric hospitalization	22	1.8
Regional center	16	1.3
Drug/alcohol services	14	1.1
Other	72	5.8

<i>To your knowledge, which of the following apply to the child's current primary caregiver, now or in the past...</i>	Caregiver	
	"Yes" response per therapist n	%
Victim of domestic violence	530	42.5
Victim of physical abuse	318	25.5
Drug/alcohol abuse	230	18.4
Extreme poverty	176	14.1
Victim of sexual abuse	152	12.2
Chronic physical illness	100	10.5
Law violations	107	8.6
Mental illness	91	7.3
Psychiatric hospitalizations	41	3.3
Suicide attempts	39	3.1

Various Areas of Functioning Prior to the CHAT Referral. Therapists documented problem areas prior to the child's referral to CHAT. See **Table 5** for details.

- Over half of the children (52%) were believed to have their *school performance* affected by the abuse incident according to therapists.
- A second most common concern was *substance abuse or alcohol abuse* occurring in the home (40%).

- An *open CPS* case was indicated in 23% of the children.
- The child taking *medications*, *being homeless*, or recovering from an *intrusive medical procedure* each occurred in 6% or less of the children.

Table 5. Various Areas of Functioning per Therapist (N = 1,248).

<i>Prior to initial CHAT referral...</i>	“Yes” response per therapist n	%
Child’s school performance affected by abuse incident	652	52.2
Substance abuse/alcohol abuse occurring in home	504	40.4
Open CPS case	291	23.3
Child taking medications for emotional or psychological symptoms	77	6.2
Child taking medications for physical ailment	72	5.8
Child taking psychotropic medications	44	3.5
Child homeless	30	2.4
Child recovering from intrusive medical procedure	13	1.3

Major or Persistent Problems at the Time of CHAT Intake. Table 6 details how often therapists indicated that a child experienced major or persistent problems at the time of the CHAT intake.

- Therapists indicated that major or persistent problems in *school performance* occurred in 24% of the children.
- This was followed by *school attendance* being affected (15%), and child’s overall *stability in the home* being affected (15%).
- Very small percentages of children using *illegal substances* or being *gang affiliated* were found (1.9% and 1.4% respectively).

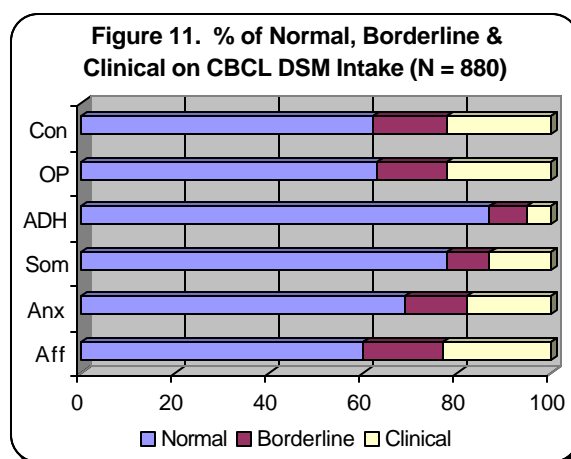
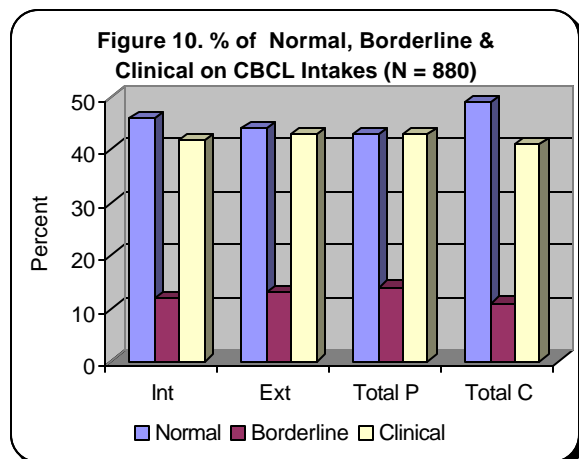
Table 6. Various Areas of Functioning per Therapist (N = 1,248).

At the time of the CHAT intake...	Major or persistent problems / to a great extent	%
	n	
Child's overall school performance	296	23.7
School attendance affected	188	15.1
Child's overall stability in the home	188	15.1
Child's use of illegal substances	24	1.9
Gang affiliation	18	1.4

Mental Health Categories of Children at Intake Based on CBCL and YSR.

Appendix G and **Figure 10** and **11** below outline the breakdown of children who fall into 3 categories of functioning (normal, borderline, clinical) according to the CBCL provided by the caregiver at intake (n = 880).

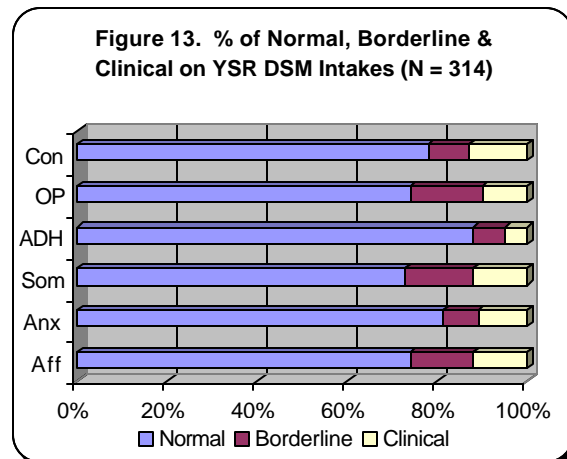
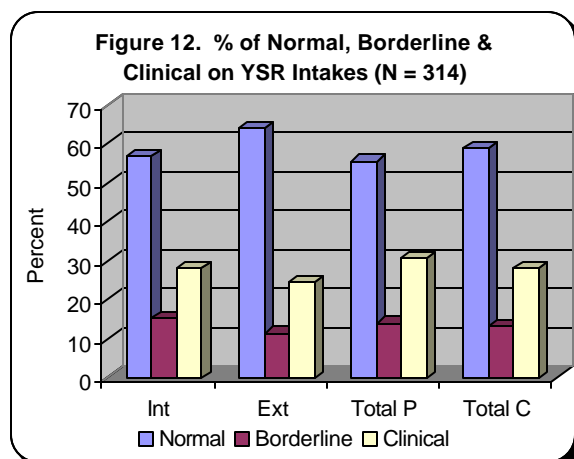
- Over 40% of the children fell into a *clinical* category based on *Internalizing* behaviors (comprised of 3 scales: anxious/depressed, withdrawn/depressed, and somatic complaints) (see **Figure 10**).
- Almost the same percentage (42.6%) of children were also in the *clinical* category based on *Externalizing* behaviors (comprised of 2 scales: rule-breaking behaviors and aggressive behaviors).
- Over 40% of children fell into the *clinical* category based on the *Total Problems* scale, which is comprised of a total of all problem items.



- About 40% of the children scored in the clinical range for *Total Competencies*, which is comprised of scales measuring activities, social, and school.
- About 16% of children exhibited a *clinical* level of *other problem behaviors* (not shown in any Figure), including social problems, thought problems, and attention problems.
- In the case of the DSM scales (this refers to the *Diagnostic and Statistical Manual*, which contains the standard diagnostic mental health categories used in assessment), the largest percentage of children fell into the *clinical* category on the *affective problems* scale (23%), followed by the *oppositional defiant* scale (22%), *conduct* problems (21.6%), and *anxiety* problems (18%) (see **Figure 11**).
- The smallest *clinical* categories on the DSM-oriented scales were *attention deficit/hyperactivity* with 4.7% and *somatic* problems (13%) (see **Figure 11**).

Appendix H and **Figures 12** and **13** below outline the breakdown of children who fall into 3 categories of functioning (normal, borderline, clinical) according to the YSR provided by youth ages 11-18 intake (n = 314).

- Based on the youth's own assessment, 28% of youth fell into a *clinical* category based on *Internalizing* behaviors (comprised of 3 scales: anxious/depressed, withdrawn/depressed, and somatic complaints) (see **Figure 12**).
- Slightly less (24.5%) youths were also in the *clinical* category based on *Externalizing* behaviors (comprised of 2 scales: rule-breaking behaviors and aggressive behaviors).
- The largest percentage of youths (30.6%) fell into the *clinical* category based on the *Total Problems* scale, which is comprised of a total of all problem items.
- Twenty-eight percent of youths scored in the clinical range for *Total Competencies*,



which is comprised of scales measuring activities, social, and school.

- Less than 15% of youths scored within a *clinical* level of *other problem behaviors* (not shown in any Figure), including social problems, thought problems, and attention problems.
- In the case of DSM-oriented scales, the largest percentage of youths fell into the *clinical* category on the *affective problems* scale (12.4%) and *conduct problems* scale (12.7%) (see **Figure 13**).
- This was closely followed by *somatic problems* (11.8%), and an almost equal number of *anxiety problems* (10.5%) and *oppositional-defiant* (10.2%).
- The smallest *clinical* categories on the DSM-oriented scales was *attention deficit/hyperactivity* with 4.8% (see **Figure 13**).

Comparison of CHAT Children with the Normed CBCL Samples. Appendix I compares mean T-scores on all scales by gender and age group among the normed CBCL samples and the CHAT sample. The CBCL sample is split into children who were referred to mental health services (*referred*) and children who were not (*non-referred*).

- Overall, the CHAT sample averages fell *between* the referred and non-referred samples, scoring higher (more problems, less competencies) than the non-referred sample, but scoring lower (less problems, more competencies) than the referred sample.
- For the *Total Competence* scale (comprised of activities, social interaction, and school performance) the average score for CHAT boys and girls of all ages was closer to the referred sample than the non-referred sample. This indicates that, according to their caregivers, CHAT children scored lower in levels of competence than a non-referred sample, and scored higher in level of competence than the referred sample.
- For the 3 problem scales (*Internalizing*, *Externalizing*, and *Total problems*), the average score for CHAT boys and girls of all ages was closer to the referred sample than the non-referred sample, indicating a higher level of problems than the non-referred sample, and a lower level of problems than the referred sample.
- For the DSM-oriented scales, the average score for CHAT children was closer to the referred samples for the following scales: *affective problems*, *anxiety problems*, and *somatic problems*.
- For *Attention deficit/hyperactivity disorder problems*, the average CHAT score was closest to the non-referred sample.

- The average CHAT score was in between the referred and non-referred sample scores without obviously being closer to one or the other for the *oppositional defiant scale* and the *conduct problems scale*.

Comparison of CHAT Children with the Normed YSR Samples. Appendix J

compares mean T-scores on all scales by gender and age group among the normed YSR samples and the CHAT sample. The YSR sample is split into youths who were referred to mental health services (*referred*) and youths who were not (*non-referred*).

- Overall, the CHAT sample averages fell *between* the referred and non-referred samples, scoring higher (more problems, less competencies) than the non-referred sample, but scoring lower (less problems, more competencies) than the referred sample.
- For the *Total Competence* scale (comprised of activities and social interaction) the average score for CHAT youth was closer to the referred sample than the non-referred sample. This indicates that, according to the CHAT youths themselves, youths scored lower in levels of competence than the non-referred sample, and scored in a higher level of competence than the referred sample.
- The only instance in which CHAT youths scored lower than the referred sample was girls on the *social competence* scale.
- For the 3 problem scales (*Internalizing*, *Externalizing*, and *Total Problems*), the average score for CHAT youth was closer to the referred sample than the non-referred sample, indicating a higher level of problems than the non-referred sample, and a lower level of problems than the referred sample.
- For the DSM-oriented scales, the average score for CHAT youths was closer to the referred samples for both genders for the *somatic problems* scale. Girls scored closer to the referred sample than boys on the *affective problems* scale and the *anxiety problems* scale.
- The average CHAT score for both genders was in between the referred and non-referred sample scores without obviously being closer to one or the other for the *Attention deficit/hyperactivity disorder*, *oppositional defiant* and the *conduct problems* scales.

Comparison of Matched CBCL and YSR Responses. The YSR's and CBCL's for youth and caregivers in the same family were matched, rendering a sample size of 248. Average T-scores were then compared on each of the CBCL syndrome scales and the DSM scales (see **Appendix K**).

- For the CBCL syndrome scales (*Internalizing, Externalizing* and *Total Problems* plus the individual scales), youth scored themselves lower in problems than their caregivers, with the differences reaching statistical significance.
- For the CBCL competencies scales (*Activities, Social* and *Total Competencies*), youth scored themselves higher in competencies than their caregivers, with the differences reaching statistical significance.
- In the case of the DSM-oriented scales, youth scored themselves lower in problems on the *affective disorder, anxiety problems, oppositional-defiant*, and *conduct problems*, with the differences reaching statistical significance.
- There was no difference between youth and caregiver scores on the *somatic problems* and *ADHD scales*.

Characteristics of Service Provision. In addition to the aggregated progress report data, child-specific service level data was collected from a total of 707 children from the 6-month cohort sample.

- Referrals to CHAT came from several sources (see **Table 7**). About one-third of all referrals came through several government agencies including *child protective services, group homes, probation, and victim witness centers*. This was the largest category of referrals.
- The second largest category of referrals came from *social service or mental health agencies or therapists*, accounting for about 20% of referrals (see **Table 7**).

Table 7. CHAT Service Level Data: Who Referred Child/Family to CHAT (N = 707).

	N	%
Who referred the child/family to CHAT?		
Child Protective Services, Child Abuse Response Team, Multi-disciplinary Interview Center, Group home, Probation, Victim Witness	205	29.0
Social service agency, mental health agency, or therapist	140	19.8
Parent / self / family / friend	131	18.5
School	87	12.3
CHAT agency	37	5.2
Police / Sheriff	35	5.0
Hospital / public health	20	2.8
Court / lawyer	16	2.3
Other	3	.4
Missing	33	4.7

- Referrals from informal sources including *parents, self-referrals, family, and friends* made up the third largest category of referrals, with 18.5% (see **Table 7**).
- *Schools* accounted for 12% of referrals and *police/sheriff agencies* accounted for 5% of referrals. *CHAT agencies* accounted for 5% of referrals (see **Table 7**).
- Several types of therapy services were provided and are shown in **Table 8**. Children could receive more than one therapy type. *Individual therapy* was the most common therapy type, provided to 75% of children.

Table 8. CHAT Service Data: Therapy Type (N = 707).

<i>Therapy type</i>	<i>n</i>	<i>Avg sessions per child</i>	<i>sd</i>	<i>Range per child</i>
Individual	536	8.64	7.55	0 to 37
Family	451	3.90	5.29	0 to 62
Group w/child (including youth groups)	244	1.95	4.67	0 to 29
Group treatment/support (not run by a therapist)	213	.28	1.86	0 to 17
Collateral contacts with child	193	.17	1.33	0 to 16
Cultural therapeutic activities	215	.18	.87	0 to 6
Personal/family advocacy sessions	220	.66	1.73	0 to 14
Other	209	1.62	4.07	0 to 35

- About 64% of children received *family therapy*; 35% received *groups* run by a therapist; and 30% of children received *groups* run by someone other than a therapist (see **Table 8**).
- The average number of *individual therapy* sessions per child was 8.64, with sessions per child ranging from 0 to 37 (see **Table 8**).
- Most children (84%) worked with the *same therapist* throughout therapeutic services, with a small percentage (8%) known to work with more than one therapist, and the information being unknown for an equal amount (8%) (see **Table 9**).

Table 9. CHAT Service Data: Continuity & Location of Therapy (N = 707).

<i>Did child/youth work with same therapist?</i>	<i>n</i>	<i>%</i>
Yes	596	84.3
No	56	7.9
Missing	55	7.8
<i>Location of therapy session</i>	<i>n</i>	<i>%</i>
At agency	568	80.3
At school site	46	6.5
At child's home	32	4.5
Other	13	1.8
Missing	48	6.8

- Most children (80%) received therapy services at the agency, with about 7% receiving therapy services at school, and about 5% receiving therapy services at home (therapy services at home was permitted under specified circumstances) (see **Table 9**).
- For 38% of the sample, *another family member* was receiving services (see **Table 10**).
- A *sibling* received the additional services for about one-third of these cases (12% it was a *sister*, another 11% it was a *brother*, and in 5.8% it was *both*). *Parents* received services in 5.5% of cases, including only the mother (3.4%) and parents/siblings together (2.1%) (see **Table 10**).

Table 10. CHAT Service Data: Family Members Receiving Services (N = 707).

<i>Was another member of family receiving services?</i> ⁵	n	%
No	412	58.3
Yes	271	38.3
Missing	24	3.4
<i>Relationship to child of family member receiving service</i>		
Sister	87	12.3
Brother	80	11.3
Sister and brother	41	5.8
Mother	24	3.4
Parent & siblings	15	2.12
Other	22	3.11
Total known	269	38.0
Missing	438	62.0

- The *length of service contacts* was known for a smaller sample of children (n = 374). Among this smaller sample, the *average days of service* from initial contact to service termination (or the end of follow-up for the evaluation) was 127, with days of service ranging from 0 to 676 (see **Table 11**).

Table 11. CHAT Service Level Data: Length of Service and Termination (N = 707).

<i>Length of Service from Contact Date to Date of Termination</i>	n	%	Avg days per child	Range (days)
Time period known	374	52.9	127 days	0 to 676
Time period unknown	333	47.1		

⁵ All services to non-offending care providers and family members were connected to the therapeutic treatment needs of the child.

- Individual therapy services had *terminated* for 62% of the sample of 707 children, with 38% *still in services* (see **Table 12**).
- Among the 62% that terminated, the most common reason was *failure to attend* (23%) (see **Table 12**).
- The child *completing therapy* accounted for about 12% of the terminations (see **Table 12**).
- The child was *transferred to other treatment* in 7% of the cases (see **Table 12**).
- In 14% of cases, treatment was terminated at the *request of the family* (8%), and due to the *family relocating* (7%) (see **Table 12**).

Table 12. CHAT Service Level Data: Length of Service and Termination (N = 707).

Reason for termination	n	%
Failure to attend / no contact / no show	163	23.1
Child completed therapy	82	11.6
Terminated at request of child/family	55	7.8
Child transferred to other treatment / Therapist	50	7.1
Family relocated	46	6.5
No reason given	14	2.0
Child removed from home or family	13	1.8
Terminated at request of court	3	.4
Missing	12	1.7
Total terminated	438	62.0
Total still in therapy	269	38.0

- Based on this sample, 73% of children *spoke English in the home*, 17% spoke *Spanish in the home*, and the remaining spoke *another language* or the information was unknown.
- Just over 20% of the children were *bilingual*, 67% were *not bilingual*, and the information was unknown for the remainder.

HOW DID CHILDREN BENEFIT FROM CHAT SERVICES?

Child's General Functioning at Pre-Post (CGAS, GARF, and CIS). Child benefits were measured by 3 standardized assessments that were documented by the therapist at the beginning of the case at intake (pretest) and 6 months after intake (posttest). These standardized assessments included the Children's Global Assessment Scale (CGAS), the Global Assessment of Relational Functioning (GARF), and the Columbia Impairment Scale (CIS).

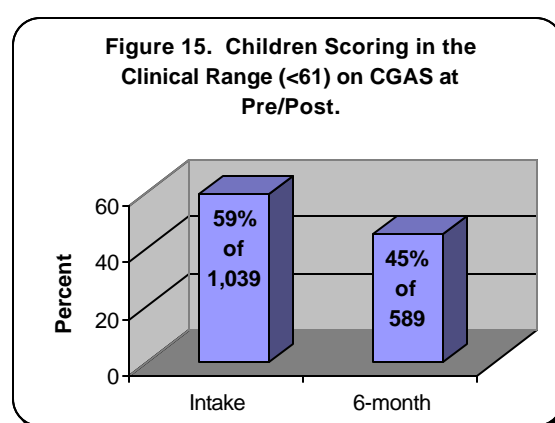
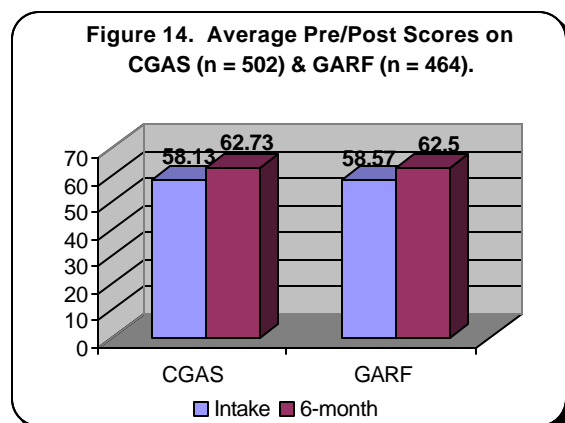
A small sample of children also received a CBCL and YSR at follow-up. However, because these samples were small compared to the entire sample (165 for the CBCL and 46 for the YSR), further analyses of these pre-post instruments were not conducted.

Appendix L and **Figures 14-17** below detail the intake and 6 month follow-up findings for the 3 therapist instruments. Each outcome measure indicated that on average, children's functioning was improved at 6 months. All pretest/posttest comparisons reached statistical significance using the paired samples t-test unless otherwise noted. This means that the differences between the pretest and post-tests were greater than what would be expected by chance.

- Children's *overall functioning* as measured by the CGAS increased by 8%, going from an average score of 58 to an average score of 62 ($t = -9.86$, $df = 501$, $p < .001$), based on a sample size of 502 children (see **Figure 14**).

This indicates that on average children went from the 51-60 range, described as "*variable functioning with sporadic difficulties or symptoms in several but not all social areas*" to the next highest level of functioning (61-70) described as "*some difficulty in a single area, but generally functioning pretty well.*"

A clinical range for the CGAS has been identified in the literature as scores below 61. Comparing the entire sample (rather than just those children who had both pretest and posttest scores), there were 13% fewer children in the clinical category at follow-up than intake (59% or 608 children scored at 61 or lower at intake and 45% or 267 children scored at 61 or lower at follow-up) (see **Figure 15**).



- Children's *relational functioning* as measured by the GARF increased by 7%, going from an average score of 59 to an average score of 63 ($t = -6.21$, $df = 463$, $p < .001$) based on a sample of 464 children (see **Figure 14**).

This indicates children went from the 41-60 range, described as “*relational unit has occasional times of satisfying and competent functioning together, but clearly dysfunctional, unsatisfying relationships tend to predominate*” to the next highest range (61-80) described as “*functioning of relational unit is somewhat unsatisfactory. Over a period of time, many but not all difficulties are resolved without complaints.*”

- The total *impairment or problem score* measuring interpersonal relations, broad psychopathology, school and work, and leisure time decreased by 26% (meaning less problems were noted), going from an average of 25 to an average of 19 out of a total possible score of 52 ($t = 9.19$, $df = 217$, $p < .001$) based on a sample of 218 children (see **Appendix M**).

Problems in *interpersonal relations* on the CIS improved by 18% for children ($t = 7.78$, $df = 260$, $p < .001$) based on a sample of 261 children (see **Figure 16**).

Problems in *broad psychopathology* on the CIS improved by 21% ($t = 10.98$, $df = 419$, $p < .001$) based on a sample of 420 children (see **Figure 16**).

Problems in *school and work* improved by 26% ($t = 8.21$, $df = 424$, $p < .001$) based on a sample of 425 children (see **Figure 16**).

Problems in *leisure time* improved by 29% ($t = 9.00$, $df = 413$, $p < .001$) based on a sample of 414 children (see **Figure 16**).

A clinical cut-off for the CIS has been identified in the literature as a total problem score of 16 or higher. Using all available data rather than just data from children who had both a pretest and a posttest, a 23% decrease in children falling into the clinical category of the CIS occurred from intake to follow-up (see **Figure 17**).

Figure 16. Average Pre/Post Scores on CIS Scales (n varies).

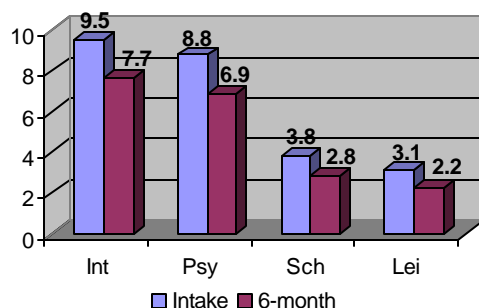


Figure 17. Children Scoring in Clinical Range (<15) for CIS at Pre/Post.

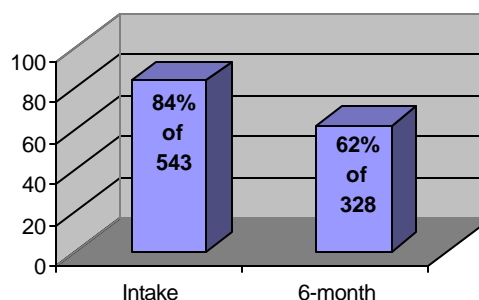


Figure 18. Post-Test CGAS by Age & Gender (n = 332).

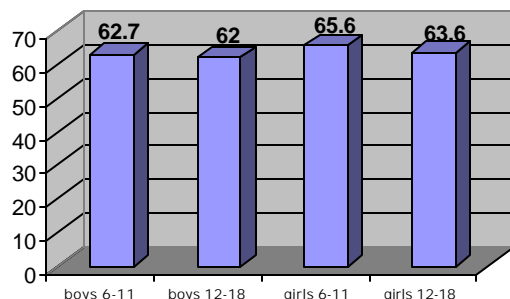
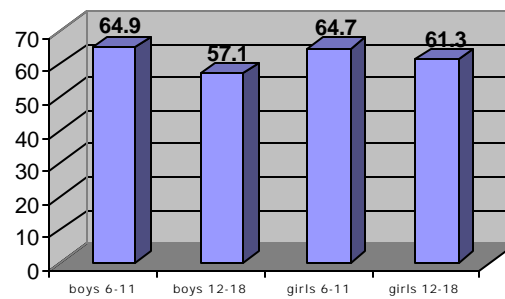


Figure 19. Post-Test GARF by Age & Gender (n = 306).



At intake, 84% or 458 children were in the clinical category based on their total problems. At follow-up, 62% or 202 children fell within the clinical category.

Age and Gender Differences in General Functioning at 6 month Follow-up.

- On average, boys from 6 to 18 did not score differently from girls 6-18 in their overall functioning as measured by the CGAS posttest scores ($F = .969$, $df = 331$, $p = .407$) (see Figure 18).
- On average, boys from 6 to 18 did not score differently from girls 6 to 18 in *relational functioning* on the post-test GARF scores ($F = .285$, $df = 305$, $p = .036$; however, all Bonferroni post-hoc tests were non-significant) (see Figure 19).
- For the *Total CIS problem* scale, on average, girls 6-11 had fewer problems at post-test than the other age and gender groups ($F = 3.012$, $df = 205$, $p = .031$) (see Figure 20).
- No differences by age or gender were found on the post-test scores for *interpersonal relations*, *broad psychopathology* or *leisure time* (Interpersonal relations: $F = 2.142$, $df = 224$, $p = .096$; Broad psychopathology: $F = 1.993$, $df = 313$, $p = .115$; Leisure time: $F = 2.135$, $df = 320$, $p = .096$) (see Figure 21).

Figure 20. Post-Test CIS by Age & Gender (n = 206).

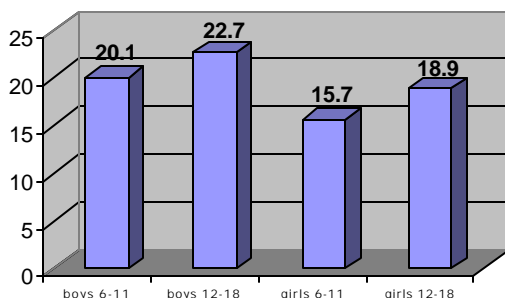
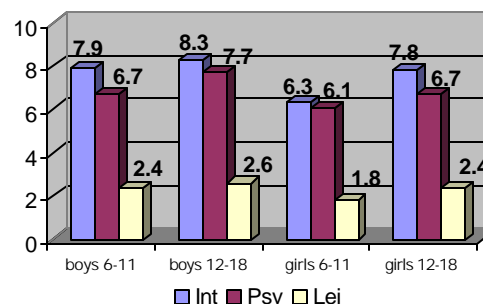
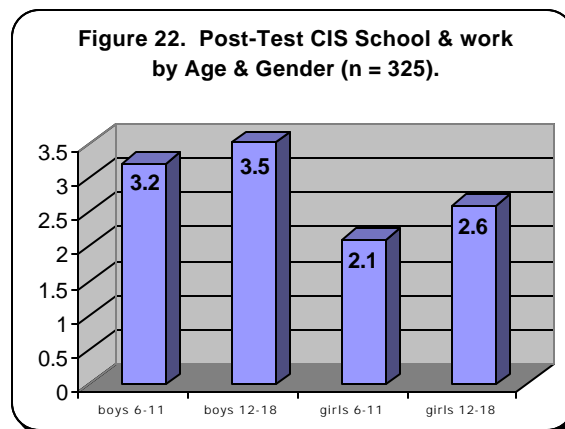


Figure 21. Post-Test CIS Scales by Age & Gender (no differences).





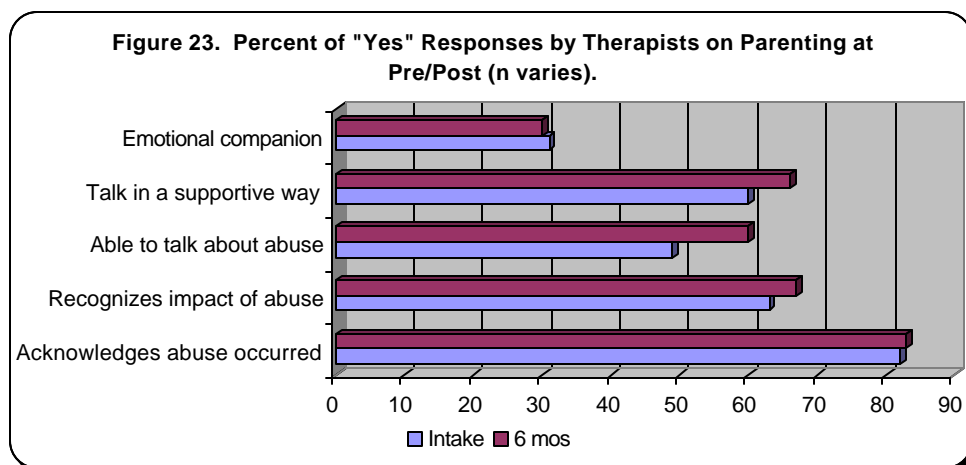
- On average, boys aged 6-18 had more problems in *school and work* than girls 6-11; these differences reached statistical significance ($F = 6.137$, $df = 324$, $p = .000$; Bonferroni post hoc tests: significant) (see **Figure 22**).

Parenting at Intake and 6-month Follow-up. A scale to measure key aspects of parenting for the non-offending parent was developed by therapists for purposes of this evaluation. Reliabilities for the 9-question scale were in the acceptable range ($\alpha = .82$ for all items at intake and $.86$ for all items at post-test). **Appendix N** provides the change in responses from pretest to posttest.

- According to therapists, there was an 11% increase in parents/caregivers' *abilities to talk about the abuse* at 6-month follow-up than at intake; this difference reached statistical significance ($\chi^2 = 18.56$, $p = .000$, $n = 365$) (see **Figure 23**).
- According to therapists, there was a 6% increase in parents/caregivers' *capabilities of setting reasonable limits* for their child's acting out behaviors at 6-month follow-up than at intake; this difference reached statistical significance ($\chi^2 = 4.75$, $p = .029$, $n = 361$) (see **Figure 24**).

The remaining questions did not reach statistical significance in terms of difference at intake and 6-month follow-up, however, responses are still informative to understanding parenting strengths and weaknesses from the perspective of therapists.

- About 30% of parents at intake and follow-up were perceived to use the child as an emotional companion (see **Figure 23**).
- Between 60-66% of parents were believed to have the capability of talking in a supportive way to their child about the abuse (see **Figure 23**).
- Between 63-67% of parents were perceived to be able to recognize the impact of the abuse on their child (see **Figure 23**).

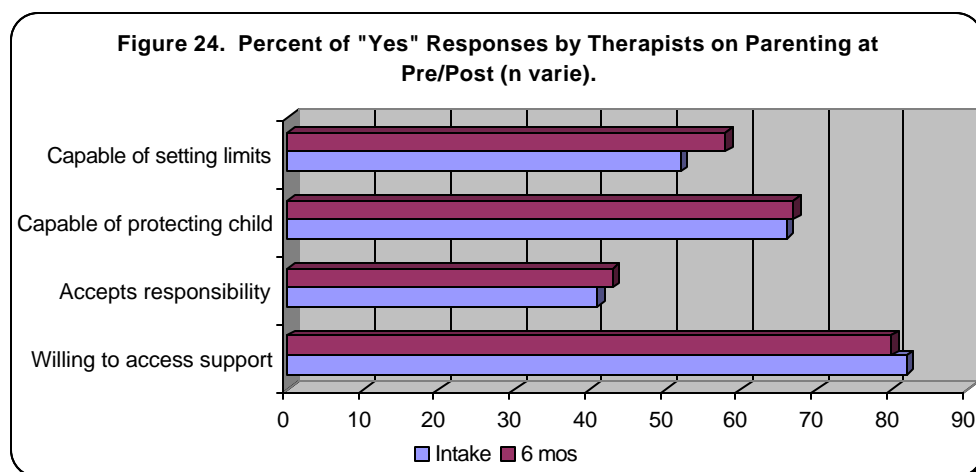


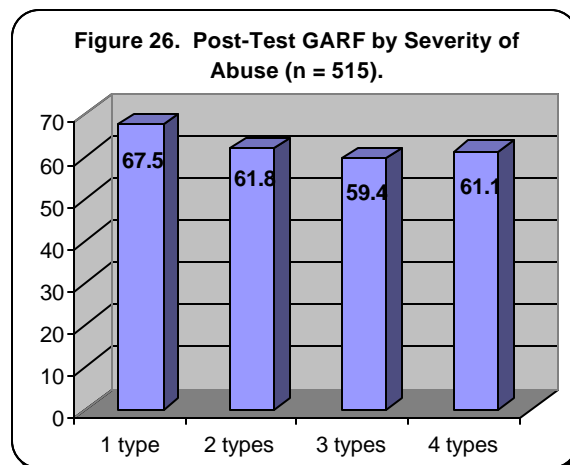
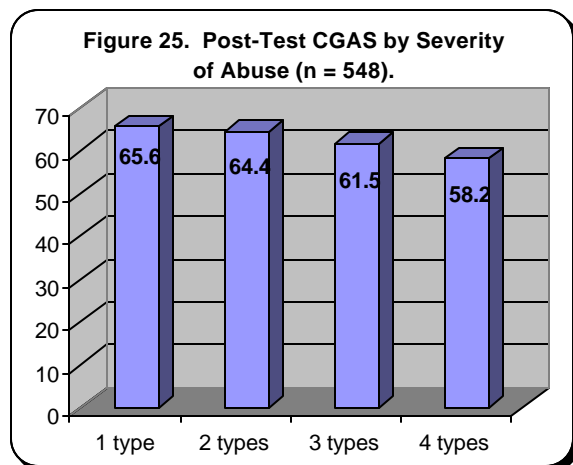
- Just over 80% of parents/caregivers were perceived to be able to acknowledge that the reported abuse occurred or was at risk of occurring (see **Figure 23**).
- About 66% of parents/caregivers were believed to be capable of protecting their child from further abuse (see **Figure 24**).
- About 40% of parents/caregivers were believed to accept responsibility for their own role in the abuse happening or the risk of abuse being present (see **Figure 24**).
- Over 80% of parents/caregivers were believed be willing to access community supports (see **Figure 24**).

What Factors Influenced Functioning at 6 months?

Post-test scores, indicating the child's functioning at 6 months, varied by severity of abuse (1, 2, 3, or 4 or more types of abuse experienced by the child).

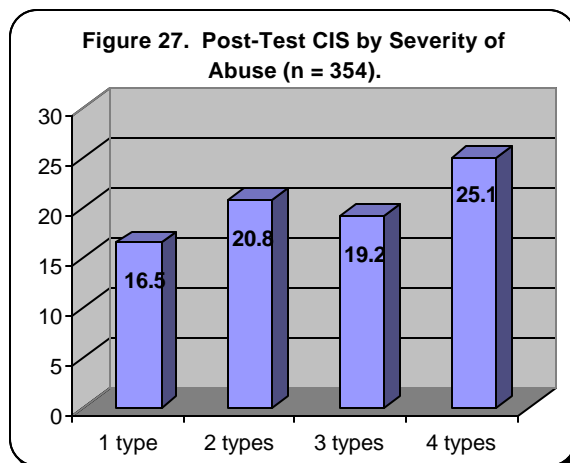
- On average, children with 1 type of abuse exhibited better *overall functioning* at





post-test as indicated by the 6-month CGAS, than children with 4 or more types of abuse. Children with 4 or more types of abuse remained within the clinical range of the CGAS (below 61) at post-test while children with 1-3 types of abuse scored outside the clinical range at post-test ($F=7.69$, $df=3$, $p=.000$) (see **Figure 25**).

- On average, children with 1 type of abuse exhibited better *relational functioning* at post-test as indicated by the 6-month GARF than children with 2, 3, or 4 or more types of abuse, who showed lower *relational functioning* ($F=8.20$, $df=3$, $p=.000$) (see **Figure 26**).
- On average, children with 1 type of abuse had *fewer problems* at post-test as indicated by the 6-month total CIS score, although they still scored within the clinical range. Children with 4 types of abuse had the *more problems* at post-test than all the other groups, and children with 2 and 3 types of abuse scored in the middle ($F=8.56$, $df=3$, $p=.000$) (see **Figure 27**).



WHAT WERE THE NON-MONETARY BENEFITS TO CHILD, FAMILIES, AND COMMUNITIES IN WHICH CHAT SERVICES WERE PROVIDED?

Benefits in child abuse treatment can be far-reaching and can impact the child, parents, families, and the community. Moreover, often these benefits cannot easily be categorized into dollar amounts. In an attempt to capture specific non-monetary ways that children benefited from CHAT services, agencies were asked to provide open-ended responses to the following question: What non-monetary benefits to the child do you see during the time that the child is receiving CHAT services?

Benefits to the child were subjected to a statistical technique referred to as “concept mapping.”⁶ This approach is conducted through the following steps:

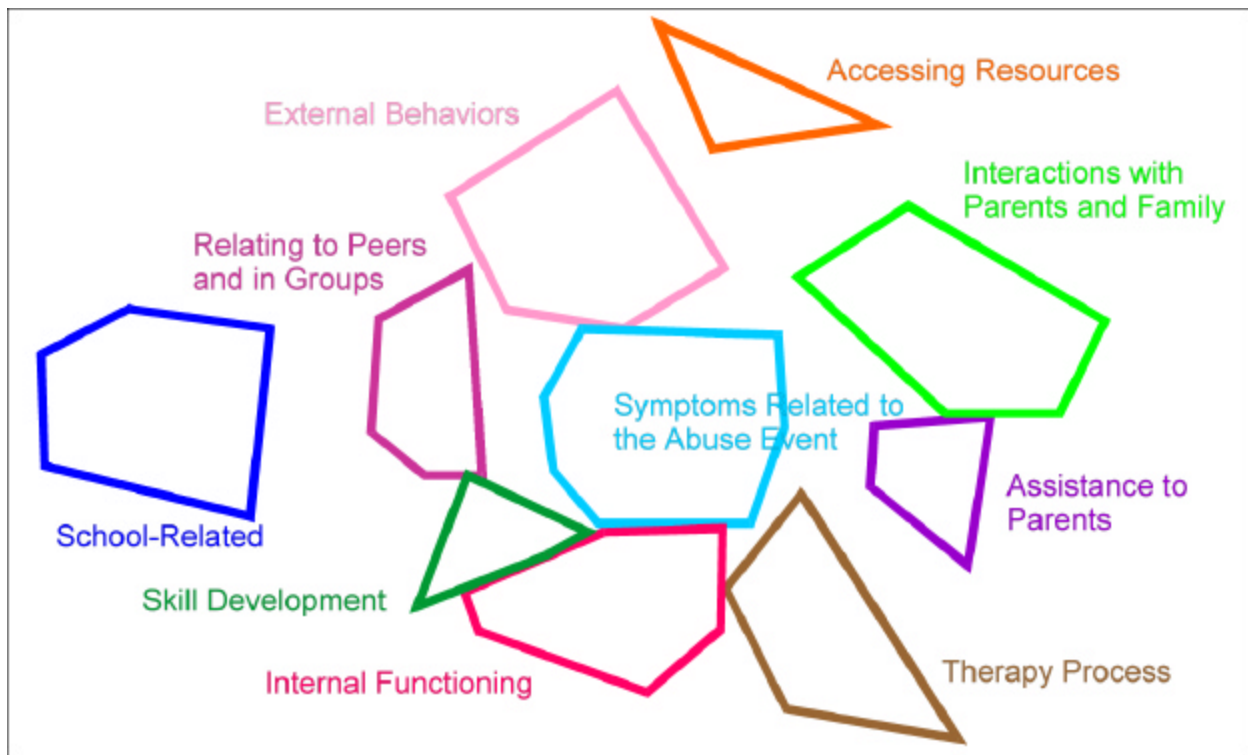
1. Agencies were asked to provide open-ended responses in the *Child Benefit Survey* (see Appendix); 34 responses were received.
2. The evaluator then merged the responses into one list of 126 benefits to children, eliminating duplications and maintaining the original wording as much as possible;
3. Each of these 126 benefits were then put onto index cards and mailed out to all agencies. Each agency was asked to sort the 126 benefits “any way that made sense” to them. Agencies also rank-ordered each benefit on a scale from “did not occur in any children” to “occurred in all children”;
4. The evaluator then subjected the sorted groups child benefits to a multidimensional scaling technique. This statistical procedure looks for an underlying structure to the data by analyzing how many times pairs of child benefits were sorted together by the different respondents. The outcome of the analysis is X-Y coordinates that are plotted on a graph.
5. These X-Y coordinates are then subjected to a hierarchical cluster analysis, which groups the statements into clusters. The researcher then determines what number of clusters is the most meaningful.
6. The end result of these 2 statistical procedures is shown in **Figure 28**.

The concept mapping approach has two distinct advantages. First, the responses that are generated across a large number of experts provide a unique opportunity to create a valid list of potential outcomes for children. The rank-ordering task allowed therapists to indicate how often they observed each benefit. Second, the clustering of the benefits provides a conceptual and analytical tool to better understand how the child benefits are perceived by therapists and what their relationship to one another might be. The clustering also suggests specific outcome areas for development in future research.

⁶ See William Trochim’s article in the Bibliography.

How did Children Benefit from CHAT Services? Therapists from 34 agencies identified 126 benefits to children. The sorting technique carried out by CHAT therapists resulted in 10 clusters or categories, shown in **Figure 28**. The figure illustrates how the statements grouped into clusters and the titles assigned by the evaluator.

Figure 28. Concept map for: “What non-monetary benefits to the child do you see during the time that the child is receiving CHAT services?”



- (1) School-related
- (2) External Behaviors
- (3) Assistance to Parents
- (4) Accessing Resources
- (5) Relating to Peers and in Groups
- (6) Therapy Process
- (7) Interactions with Parents and Family
- (8) Internal Functioning
- (9) Skill Development
- (10) Symptoms Related to the Abusive Event

A concept map is interpreted based on where the groups are placed in relation to one another. In other words, when clusters are clearly set apart from other clusters, it means that the benefits in one group were consistently sorted together by a greater number of therapists and *not* with the benefits of the second group.

- The concept map suggests that *school-related* benefits were seldom sorted with any other type of benefit. The placement of the *school-related* category is also markedly far from the two categories dealing with parents and families (*interactions with parents and family* and *assistance to parents*). This would suggest that *school-related* benefits were seen by therapists as separate from what was going on with parents and families, but were more related to what was going on with the child.

Clusters that are close to one another indicate that therapists often sorted the benefits together across these groups, suggesting that these benefits are seen as more similar. Several clusters specifically related to the child are placed close to one another in the center of the map.

- Benefits in *skill development*, *internal functioning*, and *symptoms related to the abusive event* were seen as closely related by therapists.
- The placement of the *therapy process* is closest to the child's *internalized functioning* and dealing with the *symptoms related to the abusive event*. This is not surprising given that these are the likely topics of treatment.
- *Relating to peers in groups* seems to have a close link to benefits in *skill development*, *symptoms related to the abuse*, and *external behaviors*.
- *External behaviors* is closely linked to the child's ability to deal with the *symptoms related to the abuse*.
- Benefits to parents and family (*interactions with parents and family* and *assistance to parents*) are close to one another, and alongside of benefits to the child, but clearly separate from them.
- *Accessing resources* is also clearly separate, but closest to the child benefits in *external behaviors*. This makes sense in that a child's ability to access resources may be linked to a child's control of external behaviors.
- Looking at the map from the bottom, an ordering of benefits is suggested. Via the *therapy process*, the child deals with *internal functioning*, *skill development*, and *symptoms related to the abusive event*. Dealing with these 3 areas in turn allows the child to benefit in *relating to peers and in groups* and in *external behaviors*. Alongside of this are benefits in the areas of *school*, *parents*, and *family*. Lastly, benefits in *accessing resources* occur as a consequence of benefits in *external behaviors*. This ordering is suggestive and not definitive.
- A final point to be made based on the 10 categories is that they are comprehensive, covering individual-level factors related to the child, relational or family level, school level, and community. This suggests that children benefit in a myriad of ways from CHAT treatment.

The actual benefit statements in each category are shown in **Appendix O**.

These benefits were further validated by a rating scale, in which therapists (n = 27) rated each benefit independently. The scale ranged from:

- 1 - did not occur on behalf of any children
- 2 - occurred in very few
- 3 - occurred in some
- 4 - occurred in most
- 5 - occurred in all children

Seventy-five percent of these benefits received an average score of 3.5 or higher, indicating that therapists believed that 75% of the benefits “*occurred in some children*,” “*most children*,” or “*all children*.” This indicates that most of the benefits were observed by a large sample of experienced therapists, and suggests their validity as expected outcomes for children in treatment.

Did Program Elements Work?

Seven primary program elements were identified in the Background section of this report. Evidence for whether the program element worked is presented below. In the case of some program elements, detailed information was provided in previous sections and will not be repeated here.

Requirements for Implementing Agencies

Did this Program Element Work? Yes.

Agencies were selected through a competitive process. All agencies were either governmental (18%), private/non-profit (69%) or American Indian (13%). See **Appendix D** for a listing as to agency type.

Funding Match

Did this Program Element Work? Yes.

All agencies fulfilled match requirements. Data on match amounts are not included in this report.

Direct Services

Did This Program Element Work? Yes.

Direct service provision was covered in detail in the “Were Grant Objectives Achieved” section of this report.

- Over 7,000 children received treatment services in 2001/2002.
- Services included crisis counseling, follow-up, therapy, group treatment/support, information and referral, criminal justice support and advocacy, emergency legal advocacy, assistance filing for compensation, personal advocacy, and telephone contacts.

Use of Volunteers

Did This Program Element Work? Yes, for most agencies (69%), but not all.

- Almost all agencies (69%) met or exceeded their goal for use of volunteers.
- However, 13% or 6 agencies did not utilize volunteers and 17% (8) agencies fell short of their goal.
- Agencies in rural areas and American Indian rancherias had unique issues related to volunteers. This was partly as a consequence of not having a large pool of potential volunteers available in the community due to being located in a less densely populated area, in addition to finding volunteers who were not already known to victims.
- When volunteers were recruited, the added staff time needed for training and supervision stretched already thin resources at some of the smaller agencies.
- The waiting period for background checks often caused delays.

Promote Community Efforts to Aid Crime Victims

Did this Program Element Work? Yes.

Agencies coordinated services with existing resources in their communities in a number of ways. The CHAT grant allowed agencies to immediately begin services for children who did not qualify for any other existing community resources or funding sources. Appropriate supports and funding were then pursued through links including Victim Witness and Medi-Cal. Most agencies participated in collaborative meetings in their communities in order to generate community awareness and referrals to the CHAT program as well as to make themselves aware of existing resources.

Crime Victim Compensation

Did This Program Element Work? Yes, for most agencies (52%), but not for all.

Crime victim compensation was covered in detail in the “Were Grant Objectives Achieved” section.

- Almost 3,400 children received assistance for filing victim’s compensation. This was 9% below the projected amount.

- Fifty-two percent of agencies (23) met or exceeded their projections; 48% (22) were unable to meet their projections.
- Reasons given by agencies which were unable to meet their projections included:
 - a. the family's unwillingness to file a police report due to several reasons including: families being in a state of crisis at the onset of the case, and not having the required focus to complete the necessary process for applications; reluctance to report a family member; distrust of government agencies; child has reunified with the perpetrator of the abuse; the child not being named on the police report; victims not born in the United States and subsequent inability to determine origin of birth;
 - b. inability to access police report when one was filed;
 - c. no police report was generated based on the abuse incident, such as the child not being listed as a witness in the case of witnessing domestic violence or no police report filed at all;
 - d. language and cultural issues including literacy issues;
 - e. frequent changes in eligibility and procedural requirements for filing victim compensation, and cumbersome and lengthy forms to complete;
 - f. lengthy waiting periods between filing and learning the outcome of the application process;
 - g. transportation;
 - h. clients have private insurance and are not eligible.

Provide Services to Child Victims with Disabilities

Did This Program Element Work? Yes.

- A total of 712 child victims were reported to have some type of disability across 45 CHAT agencies in 2001/2002. This represents approximately 6% of all child victims.
- Learning disabilities made up the largest category with 43% (304) of all disabilities.
- The second largest category was "other" (26% or 182). This category was comprised of a multitude of medical and psychiatric diagnoses.
- Developmental disabilities made up the third largest category with 17% (125) of all disability cases.

- Physical disabilities were the fourth largest category (10% or 74).
- The smallest category was child victims with hearing disabilities (4% or 27).

What Lessons Were Learned for Future Programs?

- A participatory or responsive evaluation procedure was carried out in order to complete the research-based goals of the evaluation. Several key lessons were learned in carrying out a multi-site evaluation over a large geographic area with a large number of agencies. Following is a brief summary:

Agency buy-in is essential in carrying out an evaluation that requires a number of agencies to utilize the same assessment instruments. Buy-in was accomplished via a 6-month development period in which all agencies were invited to participate in the selection of assessment instruments as well as for their comments on the research design in general. This period included extensive contact between the evaluator and the agencies as well as between the agencies themselves via phone, email, mail, a website, site visits, and regional meetings.

Regional meetings were conducted at two critical periods: during the development of the evaluation, and again to share preliminary findings after the first 4 months of data collection. Due to the wide geographical expanse in which agencies were located, 6 locations throughout the state were selected as host sites for regional meetings. The evaluator traveled to these sites, as did agencies in the surrounding areas. This allowed most agency personnel to travel no more than 2 hours if they wished to voluntarily participate in a regional meeting. The face-to-face contact appears to have been a key factor in motivation to participate and comply with the necessary data collection in the evaluation. These meetings also served as an invaluable source of information for the evaluator in developing the evaluation, interpretation of the data and understanding program implementation.

Sufficient resources to fund evaluation for statewide programs are needed if a coordinated and carefully planned data collection process that captures worthwhile outcomes is to be successfully implemented.

- Agency personnel at one regional meeting developed the 9 parenting questions based on therapist knowledge of key parenting factors related to abuse. These 9 questions had good reliability and also captured change across time. Child abuse agencies are urged to consider integrating these questions into their regular assessments for both practice and evaluation purposes.
- Agencies were able to provide a variety of direct services and criminal justice advocacy services with little difficulty. However, accessing, training, and supervising an appropriate pool of volunteers was problematic for agencies in some areas. Creative problem-solving in this area is warranted. Potential populations such as students, community groups, and other volunteer organizations could be considered to meet the need for volunteers, but in some

- cases, even these resources will be so minimal that a volunteer requirement may not always be feasible.
- Many families were unable to file for victim compensation funds for various reasons. Agencies should be aware of the possible reasons that requirements for victim compensation may not be met so that they can problem-solve appropriately and so that appropriate resources for the family can be directed elsewhere.

Recommendations

Before presenting the recommendations, a note on generalizability of the findings may be useful. Can the findings here be generalized on a statewide basis? Yes, with some limitations. The strongest case for generalizability to a specified population is made with a randomly selected representative sample. This method was not possible in this evaluation. The next best strategy to enhance generalizability is to gather a highly diverse sample (also referred to as heterogeneous) across multiple settings in large number. This strategy was utilized in this study. The 6-month cohort sampling approach across all agencies is believed to have reduced any systematic bias in the sample, in addition to incorporating a highly diverse group of children. While it is not recommended that these findings be generalized to any population of children at risk of child abuse, based on the large and diverse sample studied, it can be argued that these findings are generalizable to children who would be *similarly eligible* for *similarly run* CHAT programs in *similar settings*.

Recommendation 1:

Multiple and co-occurring types of abuse should be the standard for documentation rather than forcing a choice of recording only one type of abuse per child.

One of the most compelling descriptive findings in this report is that 71% of children had experienced more than one type of abuse, and 43% of child victims had experienced 3 or more types of abuse. Moreover, child outcomes at 6 months were found to be influenced by how many types of abuse the child had experienced. Most treatment programs are already aware of this situation and have adapted their programs to meet the complex therapeutic needs.

This finding has implications for documentation in two areas. First, for purposes of Federal reporting requirements, agencies must now select only one primary abuse category per child. This does not adequately capture an accurate picture of the child's experience and could result in an undercounting of the magnitude of abuse. Secondly, for purposes of program evaluation, the fact that outcomes may be directly related to the magnitude of abuse is further reason to make every effort to carefully document the magnitude of abuse for each child as accurately as possible so that a clear understanding of the relationship between treatment outcomes for children with identified types of abuse can be attained.

Recommendation 2:

The high-prevalence of the co-occurrence of child witnessing of domestic violence with other types of abuse as well as a high percentage of caregivers being victims of domestic violence suggests that the safety issues and treatment needs of domestic violence be integrated as a standard consideration in child abuse treatment programs.

Child witnessing of domestic violence emerged as the most common type of abuse, appearing alone or in conjunction with other types of abuse in more than 60% of cases. Most child abuse agencies are likely already aware of the co-occurrence of witnessing domestic violence and child abuse. This evaluation provides further evidence of this co-occurrence. Implications include all agencies being prepared to address the necessary safety issues and treatment needs of the child and the adult victim of domestic violence alongside of child abuse treatment needs.

Recommendation 3:

Standardized assessment instruments at regular intervals that include intake and at least one follow-up should be incorporated into all future grant requirements for child abuse treatment programs. At a minimum, the CGAS could be incorporated by all funded agencies. The CIS is also a good potential instrument.

Common assessment instruments are one way to compare data across agencies. The findings in this evaluation indicate that the CGAS and the CIS had excellent reliability and adequately captured change in a 6-month period. Child abuse agencies ought to consider permanent integration of these 2 instruments or similarly well-validated instruments for practice and evaluation purposes.

The CGAS is a one-number child functioning measure that is straight-forward to determine while also being informative. It was designed specifically to assess a child's functioning rather than adapting an instrument developed for an adult. It is in the public domain (free to use), fast to implement, very easy to learn, and it can capture change across time. If child abuse treatment agencies only incorporate one standardized outcome measure, the CGAS would be an excellent choice.

The CIS is a 13-question instrument that can be completed by the therapist on a periodic basis and provide information on 4 scales, a total scale, and it has a research-tested clinical cut-off. It also is in the public domain, fast to implement, easy to learn, and it can capture change across time. The CIS provides greater information than the CGAS. The CIS and CGAS works well in conjunction with each other because they are highly correlated (when one score goes up, the other score goes up).

Recommendation 4:

Particularly for English-speaking populations, the CBCL and the YSR are recommended as possible intake instruments for agencies with the resources to immediately score

these instruments. Follow-up administrations were found to be difficult to administer. For Spanish-speaking populations, agencies should pursue reliability-checks to determine if the Spanish-language CBCL is appropriate.

The CBCL is a useful instrument, which its greater than 20-year history can attest. However, reliabilities varied across the English-speaking sample, the Latino sample (can be English or Spanish-speaking), and the Spanish-speaking sample. Reliabilities were highest for the English-speaking sample. Reliabilities for the competence scales were in the unacceptable range for all groups. Further research is needed to discern whether these low reliabilities gained among the Spanish-speaking population were an anomaly, or if the syndrome scale is not suited for this population.

A 6-month CBCL was not received for most cases. This may have been due in part to the children not remaining in services for 6 months. It could also be due to the difficulty in getting a readministration of the CBCL from the parent or caregiver given its length.

At the same time, the CBCL/YSR bring the ability to compare the child's data with a normed sample. This makes the scoring of the CBCL/YSR of immediate use in case planning and as a useful barometer by which to assess child functioning. The information that is gathered is extremely useful on an intake basis, as well as on an ongoing assessment basis. Agencies that have the resources to purchase the instrument and the scoring software, have the staff available to immediately score the instruments for integration into case planning, and are working with a client population willing to fill it out on an ongoing basis, ought to consider use of this instrument. If a Spanish-speaking population is being served, ongoing assessment of reliabilities should be carried out to determine the usefulness of the instrument for this population.

Recommendation 5:

Several outcomes of child abuse treatment were identified that can be integrated into future practice and evaluation of child abuse programs. To the extent that agencies can access it, attempts should be made to collect information on as many of these 10 areas as possible. Grant funders should consider incorporating incentives to agencies that successfully collaborate, particularly with schools, so that children's needs can be identified early and met on a preventive basis.

Based on information generated and validated by over 30 agencies, 10 key areas of outcomes or benefits to children were identified. School-related outcomes were included among the 10, as well as a child's peer interaction. Major or persistent problems in school performance and school attendance were also noted by therapists. Agencies ought to consider collaborating with schools to adequately capture future outcome measures of child abuse treatment. Further research should continue to develop these outcomes further in a validated instrument to be used at child abuse treatment agencies.

Recommendation 6:

Based on their CBCL, CIS, and CGAS scores, a large percentage of children in the CHAT program were in need of therapeutic services at intake. In addition, program implementation appears to be cost-effective when considering an average cost per service. Ongoing funding should be pursued so that children in need can continue to access the continuum of services available in these child abuse treatment services agencies.

At intake, over 40% of children fell into a clinical category for internalizing behaviors, externalizing behaviors and total problems, as measured by the CBCL. Children in the CHAT treatment program consistently scored between the normed non-referred and referred samples. This is strong evidence that these children do indeed need therapy services. In 2001/2002, over 50,000 service contacts were documented at an average cost of \$177 each. Over 10,000 clients were served at an average cost of \$860 per client. This suggests that services are cost-effective. Ongoing provisions should be made to keep treatment services easily available to this population of children.

Recommendation 7:

On average, children's post-test scores showed improvement over their pre-test scores in a 6-month follow-up. However, not all children will show improvement in the short-term. Longer-term follow-ups are needed to more accurately represent how children's functioning changes over time and to determine an adequate length of treatment.

Children's overall functioning as measured by the CGAS, the GARF, and the CIS was found to improve from between 8% to 26%, with the differences from intake to 6 months reaching statistical significance (meaning these differences are more than what would be expected by chance). However, not all children will improve in a 6-month follow-up, nor should this be expected. At 6-months, 45% of children remained in the clinical range in overall functioning based on the CGAS, and 62% of children remained in the clinical range in overall problems based on the CIS. Longer-term follow-ups are needed to ascertain the appropriate length of treatment based on outcome measures of child functioning, and child abuse treatment should be funded accordingly.

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APPENDICES

Appendix A

Table A1. CHAT Agencies Starting in 2000/2001 & 2001/2002.

Started 2000/2001	Started 2001/2002
Comprehensive Youth Services / Fresno	Aldea Children and Family Services / Napa
County of Del Norte Victim Witness / Crescent City	Bay Area American Indian Council, Inc. / Oakland
County of Glenn Human Resource Agency / Willows	Child Abuse Listening & Mediation / Santa Barbara
County of Marin District Attorney's Office / San Rafael	CARE Children's Counseling Center / Santa Rosa
Eastern Sierra Family Resource Center / Mammoth Lakes	Child Abuse Prevention Council of Placer Co. / Roseville
Family Service Association of Western Riverside County / Riverside	Child & Family Guidance Center / Northridge
Family Services of Tulare County / Visalia	Child Haven, Inc. / Vacaville
Harvest of Wellness Foundation / Joshua Tree	Child and Family Institute / Sacramento
Humboldt Department of Mental Health / Eureka	Children's Hospital Oakland / Oakland
Interface Children Family Services of Ventura County / Camarillo	Children's Institute International / Los Angeles
Marjaree Mason Outpatient Clinic / Fresno	Clinica Sierra Vista / Lamont
New Directions to Hope / Redding	County of Orange FACT Program / Santa Ana
Reach Clinical Services / Grass Valley	Family Service Agency of San Mateo County / Burlingame
STAND / Concord	Feather River Tribal Health, Inc. / Oroville
Valley Community Counseling / Stockton	For the Child, Inc. / Long Beach
Women's Crisis Center / Salinas	Home Start, Inc. / San Diego
Women's Shelter Program / San Luis Obispo	Humane Society of Sonoma County / Santa Rosa
Youth for Change / Paradise	Indian Child Welfare Consortium / Temecula
	Indian Health Council / Pauma Valley
	Karuk Tribe of California / Happy Camp
	New Morning Youth & Family Services, Inc. / Placerville
	Plumas Rural Services, Inc. / Quincy

Appendix A

Table A1. CHAT Agencies Starting in 2000/2001 & 2001/2002.

Started 2000/2001	Started 2001/2002
	<p>Regents, University of California (CAARE) / Sacramento</p> <p>Shasta County District Attorney / Redding</p> <p>Sutter Lakeside Community Services / Lakeport</p> <p>Two Feathers Native American Family Services / McKinleyville</p> <p>Yuba County Victim Witness / Marysville</p>

Appendix B

INTAKE QUESTIONS – FOR THERAPIST COMPLETION – CGAS (CHILD 4 – 17)

Please rate the child's most impaired level of general functioning at intake by selecting one number to indicate the *lowest level* which describes the child's functioning on a continuum of health-illness. Please rate actual functioning regardless of treatment or prognosis. The examples of behavior provided are only illustrative and are not required for a particular rating. (Schaeffer, et al., 1983)

YOUR RATING FOR THIS CHILD AT INTAKE: _____

The rating scale is as follows (examples are provided below):

	91-100	Superior functioning
	81-90	Good functioning
	71-80	No more than slight impairment in functioning
	61-70	Some difficulty in a single area, but generally functioning pretty well
	51-60	Variable functioning with sporadic difficulties or symptoms in several but not all social areas
	41-50	Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area
	31-40	Major impairment in functioning in several areas and unable to function in one of these areas
	21-30	Unable to function in almost all areas
	11-20	Needs considerable supervision
	1-10	Needs constant supervision
(91-100) Superior functioning in all areas (at home, at school, and with peers); involved in a wide range of activities and has many interests (e.g. has hobbies or participates in extracurricular activities or belongs to an organized group such as Scouts, etc.); likeable, confident; "everyday worries" never get out of hand; doing well in school; no symptoms.		(41-50) Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area , such as might result from, for example, suicidal preoccupations and ruminations, school refusals and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor or inappropriate social skills, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships.
(81-90) Good functioning in all areas; secure in family, school, and with peers; there may be transient difficulties and "everyday" worries that occasionally get out of hand (e.g. mild anxiety associated with an important exam, occasionally "blowups" with sibling, parents, or peers)		(31-40) Major impairment in functioning in several areas and unable to function in one of these areas , i.e., disturbed at home, at school, with peers, or in society at large, e.g. persistent aggression without clear instigation; markedly withdrawn and isolated behavior due to either mood or thought disturbance, suicidal attempts with clear lethal intent; such children are likely to require special schooling (but this is not sufficient criterion for inclusion in this category)
(71-80) No more than slight impairment in functioning at home, at school, or with peers; some disturbance of behavior or emotional distress may be present in response to life stresses (e.g. parental separations, deaths, birth of a sibling), but these are brief and interference with functioning is transient; such children are only minimally disturbing to others and are not considered deviant by those who know them.		(21-30) Unable to function in almost all areas , e.g., stays at home, in ward, or in bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in reality testing or serious impairment in communication (but this is not a sufficient criterion for inclusion in this category).
(61-70) Some difficulty in a single area, but generally functioning pretty well (e.g. sporadic or isolated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor difficulties with school work; mood changes of brief duration; fear and anxieties which do not lead to gross avoidance behavior; self-doubts); has some meaningful interpersonal relationships; most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.		(11-20) Needs considerable supervision to prevent hurting other or self (e.g. frequently violent, repeated suicide attempts) or to maintain personal hygiene or gross impairment in all forms of communication, e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.
(51-60) Variable functioning with sporadic difficulties or symptoms in several but not all social areas ; disturbances would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.		(1-10) Needs constant supervision (24-hr care) due to severely aggressive or self-destructive behavior or gross impairment in reality, communication, cognition, affect, or personal hygiene.

Appendix B

INTAKE QUESTIONS – FOR THERAPIST COMPLETION – GARF (ALL CHILDREN)

Global Assessment of Relational Functioning (GARF) Scale from DSMIV-R

Instructions: The GARF Scale can be used to indicate an overall judgment of the functioning of a family or other ongoing relationship on a hypothetical continuum ranging from competent, optimal relational functioning to a disrupted, dysfunctional relationship. It is analogous to Axis V (Global Assessment of Functioning Scale) provided for individuals in DSM-IV. The GARF Scale permits the clinician to rate the degree to which a family or other ongoing relational unit meets the affective or instrumental needs of its members in the following areas:

- A. *Problem solving*—skills in negotiating goals, rules, and routines; adaptability to stress; communication skills; ability to resolve conflict;
- B. *Organization*—maintenance of interpersonal roles and subsystem boundaries; hierarchical functioning; coalitions and distribution of power, control, and responsibility
- C. *Emotional climate*—tone and range of feelings; quality of caring, empathy, involvement, and attachment/commitment; sharing of values; mutual affective responsiveness, respect, and regard; quality of sexual functioning.

In most cases, the GARF scale should be used to rate functioning during the current period i.e., the level of relational functioning at the time of evaluation). In some settings, the GARF Scale may also be used to rate functioning for other time periods (i.e., the highest level of relational functioning for at least a few months during the past year).

Note: Use specific, intermediate codes when possible, for example, 45, 68, 72. If detailed information is not adequate to make specific ratings, use midpoints of the five ranges, that is, 90, 70, 50, 30, or 10.

YOUR GARF SCORE FOR THIS FAMILY AT INTAKE: _____

(81-100): *Relational unit is functioning satisfactorily from self-report of participants and from perspectives of observers.*

Agreed-on patterns or routines exist that help meet the usual needs of each family/ couple member; there is flexibility for change in response to unusual demands or events; and occasional conflicts and stressful transitions are resolved through problem-solving communication and negotiation.

There is a shared understanding and agreement about roles and appropriate tasks, decision making is established for each functional area, and there is recognition of the unique characteristics and merit of each subsystem (e.g., parents/spouses, siblings, and individuals).

There is a situationally appropriate, optimistic atmosphere in the family; a wide range of feelings is expressed and managed within the family; and there is a general atmosphere of warmth, caring, and sharing of values among all family members. Sexual relations of adult members are satisfactory.

(41-60): *Relational unit has occasional times of satisfying and competent functioning together, but clearly dysfunctional, unsatisfying relationships tend to predominate.*

Communication is frequently inhibited by unresolved conflicts that often interfere with daily routines; there is significant difficulty in adapting to family stress and transitional change.

Decision making is only intermittently competent and effective; either excessive rigidity or significant lack of structure is evident at these times. Individual needs are quite often submerged by a partner or a coalition.

Pain or ineffective anger or emotional deadness interfere with family enjoyment. Although there is some warmth and support for members, it is usually unequally distributed. Troublesome sexual difficulties between adults are often present.

(61-80): *Functioning of relational unit is somewhat unsatisfactory. Over a period of time, many but not all difficulties are resolved without complaints.*

Daily routines are present but there is some pain and difficulty in responding to the unusual. Some conflicts remain unresolved, but do not disrupt family functioning.

Decision making is usually competent, but efforts at control of one another quite often are greater than necessary or are ineffective. Individuals and relationships are clearly demarcated but sometimes a specific subsystem is depreciated or scapegoated.

A range of feeling is expressed, but instances of emotional blocking or tension are evident. Warmth and caring are present but are marred by a family member's irritability and frustrations. Sexual activity of adult members may be reduced or problematic.

(21-40): *Relational unit is obviously and seriously dysfunctional; forms and time periods of satisfactory relating are rare.*

Family/couple routines do not meet the needs of members; they are grimly adhered to or blithely ignored. Life cycle changes, such as departures or entries into the relational unit, generate painful conflict and obviously frustrating failures of problem-solving.

Decision making is tyrannical or quite ineffective. The unique characteristics of individuals are unappreciated or ignored by either rigid or confusingly fluid coalitions.

There are infrequent periods of enjoyment of life together; frequent distancing or open hostility reflect significant conflicts that remain unresolved and quite painful. Sexual dysfunction among adult members is commonplace.

(1-20): *Relational unit has become too dysfunctional to retain continuity of contact and attachment.*

Family/couple routines are negligible (e.g., no mealtime, sleeping, or waking schedule); family members often do not know where others are or when they will be in or out; there is a little effective communication among family members.

Family/couple members are not organized in such a way that personal or generational responsibilities are recognized. Boundaries of relational unit as a whole and subsystems cannot be identified or agreed on. Family members are physically endangered or injured or sexually attached.

Despair and cynicism are pervasive; there is little attention to the emotional needs of others; there is almost no sense of attachment, commitment, or concern about one another's welfare.

Appendix B

INTAKE QUESTIONS FOR THERAPIST COMPLETION (CHILD 6 – 17) CIS (Bird, 1983)

In general, how much of a problem do you think this child/youth has:							
	0 No problem	1	2 Some problem	3	4 A very bad problem	Not applic- able	Don't know
...getting into trouble?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
...getting along with mother/ mother figure (caregiver)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...getting along with father / father figure (caregiver)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...feeling unhappy or sad?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
How much of a problem would you say the child/youth has:							
	0 No problem	1	2 Some problem	3	4 A very bad problem	Not applic- able	Don't know
...with his/her behavior at school?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...with having fun?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
...getting along with adults other than parents/ caregivers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
How much of a problem would you say the child/youth has:							
	0 No problem	1	2 Some problem	3	4 A very bad problem	Not applic- able	Don't know
...with feeling nervous or afraid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
...getting along with siblings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...getting along with other kids his/her age?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
How much of a problem would you say the child/youth has:							
	0 No problem	1	2 Some problem	3	4 A very bad problem	Not applic- able	Don't know
...getting involved in activities like sports or hobbies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
...with school work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...with his/her behavior at home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
In your opinion, how sympathetic or empathetic is this child/youth towards other people on a scale from one to five:							
Child's level of empathy for others (responds to other people's emotions)	<input type="checkbox"/> 1 Very slightly or not at all	<input type="checkbox"/> 2	<input type="checkbox"/> 3 Somewhat	<input type="checkbox"/> 4	<input type="checkbox"/> 5 Extremely		
Child's level of empathy for others (is able to take perspective of another)	<input type="checkbox"/> 1 Very slightly or not at all	<input type="checkbox"/> 2	<input type="checkbox"/> 3 Somewhat	<input type="checkbox"/> 4	<input type="checkbox"/> 5 Extremely		

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PARENTING – TO BE COMPLETED BY THERAPIST AT INTAKE – ALL CHILDREN

We would like to know your perceptions of the parenting style of the non-offending parent or primary caregiver around the time that the child was referred to CHAT. In the instance in which a child has been newly placed with a foster caregiver, and the caregiver is AWARE of the abuse that occurred, ONLY QUESTION 6 MAY NOT APPLY. In the case in which the foster caregiver is UNAWARE of the abuse that brought the child to treatment, then QUESTIONS 1-3 AND QUESTION 6 MAY NOT APPLY. Please use the “Don’t know/not applicable” category when needed in these instances.

So that we can better analyze these questions, PLEASE INDICATE THE CAREGIVER TO WHOM YOU ARE REFERRING IN THESE QUESTIONS (please give relationship to the child):

CAREGIVER: _____

At the time of the CHAT referral, based on your clinical judgment...

1. Do you think the parent/caregiver acknowledges (agreed) that the reported abuse occurred or was at risk of occurring?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know / Not applicable
2. Do you think the parent/caregiver recognizes the impact of the abuse on the child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know / Not applicable
3. Do you think the parent/caregiver is able to talk to the child about the abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know/ Not applicable
IF YES, do you think the parent/caregiver is able to talk in a supportive way with the child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
4. Do you think the parent/caregiver uses the child as an emotional companion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
5. Do you think the parent/caregiver is willing to access community support in any way?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
6. Do you think the parent/caregiver accepts responsibility for his or her role in the abuse happening or for the risk of abuse being present?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know / Not applicable
7. Do you think the parent/caregiver is capable of taking steps to protect the child from further abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
8. Do you think the parent/caregiver is capable of setting reasonable limits for the child's acting out behaviors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know

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VARIOUS AREAS OF FUNCTIONING – TO BE COMPLETED BY THERAPIST FOR ALL CHILDREN AT INTAKE (FIRST 6 WEEKS)			
<p>We would like to know about various other factors that contribute to the child's environment and that may affect the child's functioning. These factors may be important in understanding whether or not children benefit from CHAT services. This is intended as a broad description of the type of environment that the child was living in at the time of the CHAT referral (<u>right before starting treatment</u>) and/or current issues to which the child is being exposed. Based on your clinical judgment...</p>			
	Yes	No	Don't know
1. Do you believe that substance abuse or alcohol abuse was occurring in the child's home <u>prior to the initial CHAT referral (before beginning treatment)</u> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>1A. IF YES, who do you think was drinking or using drugs (i.e., father, mother, stepfather, boyfriend of mother, relative) (please indicate relationship to child):</p> 			
<p>1B. IF YES, how often do you think alcohol/drug use was occurring?</p>			
<input type="checkbox"/> Daily <input type="checkbox"/> Every week <input type="checkbox"/> Every month <input type="checkbox"/> Every other month	<input type="checkbox"/> 3 or 4 times a year <input type="checkbox"/> Less than 3 or 4 times a year <input type="checkbox"/> Only once that I know of		
	Yes	No	Don't know
2. Is the child <u>currently</u> taking any <u>medications</u> for emotional and/or psychological symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>2A. If YES, what condition is the <u>medication</u> intended to address:</p> 			
	Yes	No	Don't know
2B. If NO, has the child ever taken psychotropic <u>medications</u> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Don't know
3. Is the child <u>currently</u> taking any <u>herbal remedies</u> for either psychological/emotional or physical symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>3A. If YES, what condition is the <u>herbal remedy</u> intended to address:</p> 			
	Yes	No	Don't know
3B. If NO, has the child ever taken <u>herbal remedies</u> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	Yes	No	Don't know
4. Is the child <u>currently</u> taking any <u>medications</u> for a physical ailment or symptom?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4A. If YES, what condition is the <u>medication</u> intended to address:			
	Yes	No	Don't know
4B. If NO, has the child ever taken any <u>medication</u> for a long-term or persistent physical ailment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Don't know
5. Is the child <u>currently</u> recovering from an <u>intrusive surgical or medical</u> procedure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5A. If YES, what condition was the <u>procedure</u> intended to address:			
	Yes	No	Don't know
5B. If NO, has the child ever had an <u>intrusive surgical or medical</u> procedure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How would you rate the child's overall school performance around the time of intake?			
<input type="checkbox"/> Don't know	<input type="checkbox"/> Child functions well at school	<input type="checkbox"/> Child has minor problems with attendance or getting homework in, but overall is progressing with his/her peer group	<input type="checkbox"/> Child has major or persistent problems with attendance, performance, or disciplinary issues
7. Do you believe the child's overall school performance has been affected by the abuse/neglect and/or trauma around the time of intake?			
<input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Don't know
8. To what extent do you believe the child's attendance has been affected by the abuse/neglect and/or trauma around the time of intake?			
<input type="checkbox"/> Don't know	<input type="checkbox"/> Not at all	<input type="checkbox"/> Somewhat / occasionally	<input type="checkbox"/> A lot
9. To what extent do you believe the child is involved with other youth who are gang-affiliated around the time of intake?			
<input type="checkbox"/> Don't know	<input type="checkbox"/> Not at all	<input type="checkbox"/> Marginally	<input type="checkbox"/> To a great extent
10. How would you rate the child's overall stability in the home around the time of intake?			
<input type="checkbox"/> Child's home life is reasonably stable - (i.e., living with the same parent or caregiver, has not been moved around a lot, attends the same school several years in a row, may be in foster care but has not been moved often)	<input type="checkbox"/> Child's home life is mildly disrupted (i.e., child has been moved or family has moved several times; child has changed schools mid-year; child may be in foster care placement and has been moved one or more times in the last year)	<input type="checkbox"/> Child's home life is severely disrupted - (i.e., multiple moves with family or due to foster care placements; child has attended several schools over the last one to two years, or a generally chaotic home life)	
<input type="checkbox"/> Don't know			

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[illegible]

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15. <u>If it is part of your existing intake procedure</u> , please indicate the numerical codes for the five axes diagnosis for this child at intake :
Axis IA:
Axis 1B:
Axis 1C:
Axis II:
Axis III:
Axis IV:
Axis – Current GAF Score:

16. To your knowledge, what agencies has the child been involved with <u>now or in the past</u> ?	17. To your knowledge, which of the following apply to the child's <u>current primary caregiver, now or in the past</u> ?																																																																																								
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 30%;"></th> <th style="width: 10%;">Yes</th> <th style="width: 10%;">No</th> <th style="width: 10%;">Unk</th> </tr> <tr><td>Child Protective Svcs (CPS)</td><td></td><td></td><td></td></tr> <tr><td>Juvenile Justice/Probation</td><td></td><td></td><td></td></tr> <tr><td>Special Education</td><td></td><td></td><td></td></tr> <tr><td>Drug/Alcohol Services</td><td></td><td></td><td></td></tr> <tr><td>Regional Center</td><td></td><td></td><td></td></tr> <tr><td>Psychiatric hospitalizations</td><td></td><td></td><td></td></tr> <tr><td>County mental health / suicide attempts</td><td></td><td></td><td></td></tr> <tr><td>Other</td><td></td><td></td><td></td></tr> <tr><td>Please explain:</td><td></td><td></td><td></td></tr> <tr><td> </td><td></td><td></td><td></td></tr> </table>		Yes	No	Unk	Child Protective Svcs (CPS)				Juvenile Justice/Probation				Special Education				Drug/Alcohol Services				Regional Center				Psychiatric hospitalizations				County mental health / suicide attempts				Other				Please explain:								<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 30%;"></th> <th style="width: 10%;">Yes</th> <th style="width: 10%;">No</th> <th style="width: 10%;">Unk</th> </tr> <tr><td>Psychiatric hospitalization</td><td></td><td></td><td></td></tr> <tr><td>Drug/alcohol abuse</td><td></td><td></td><td></td></tr> <tr><td>Chronic physical illness</td><td></td><td></td><td></td></tr> <tr><td>Law violations</td><td></td><td></td><td></td></tr> <tr><td>Suicide attempts</td><td></td><td></td><td></td></tr> <tr><td>Extreme poverty</td><td></td><td></td><td></td></tr> <tr><td>Mental illness</td><td></td><td></td><td></td></tr> <tr><td>Victim of domestic violence</td><td></td><td></td><td></td></tr> <tr><td>Victim of physical abuse</td><td></td><td></td><td></td></tr> <tr><td>Victim of sexual abuse</td><td></td><td></td><td></td></tr> </table>		Yes	No	Unk	Psychiatric hospitalization				Drug/alcohol abuse				Chronic physical illness				Law violations				Suicide attempts				Extreme poverty				Mental illness				Victim of domestic violence				Victim of physical abuse				Victim of sexual abuse			
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Appendix B

ABUSE HISTORY – TO BE COMPLETED BY THERAPIST FOR ALL CHILDREN AND SUBMITTED AFTER 6 MOS OF TREATMENT OR TERMINATION

ADMINISTRATION: We are interested in the child's perspective of his or her experience of abuse **prior to receiving treatment in the CHAT program**. Some therapists pursue these types of questions at some point during treatment and others do not. We are interested in knowing whether any of these types of abuse were discussed, and if so, what the child's perceptions were, as well as what your perceptions were. Please complete the information below **based on your interactions with the child during the first six months of treatment**.

1. DID THE CHILD INDICATE THAT HE OR SHE EXPERIENCED PHYSICAL ABUSE PRIOR TO THE CHAT REFERRAL?

(For example, being slapped, punched, kicked, struck with an object)

YES

NO

IF YES, how many times did the child indicate it ever happened?

_____ One time/not often

_____ A few times/occasionally

_____ More than a few times/often

_____ PLEASE CHECK HERE IF THIS AREA WAS NEVER DISCUSSED WITH THE CHILD

2. **BASED ON YOUR CLINICAL JUDGMENT, DO YOU BELIEVE THIS CHILD WAS BEING PHYSICALLY ABUSED AT ANY TIME PRIOR TO THE INITIAL CHAT REFERRAL?**

YES

NO

DON'T KNOW

IF YES, who do you think the perpetrator(s) of the abuse was (please indicate relationship to child):

IF YES, how often do you think the physical abuse occurred?

_____ One time/not often

_____ A few times/occasionally

_____ More than a few times/often

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3. DID THE CHILD INDICATE THAT HE/SHE EXPERIENCED EMOTIONAL ABUSE PRIOR TO THE CHAT REFERRAL?

(For example, being called names by a grown-up, such as “dumb” or “stupid”, or verbally criticized in an excessive way)

YES

NO

IF YES, how many times did the child indicate it ever happened?

_____ One time/not often

_____ A few times/occasionally

_____ More than a few times/often

_____ PLEASE CHECK HERE IF THIS AREA WAS NEVER DISCUSSED WITH THE CHILD

4. **BASED ON YOUR CLINICAL JUDGMENT, DO YOU BELIEVE THIS CHILD WAS BEING EMOTIONALLY ABUSED AT ANY TIME PRIOR TO THE INITIAL CHAT REFERRAL?**

YES

NO

DON'T KNOW

IF YES, who do you think the perpetrator(s) of the abuse was (please indicate relationship to child):

IF YES, how often do you think the emotional abuse occurred?

_____ One time/not often

_____ A few times/occasionally

_____ More than a few times/often

5. DID THE CHILD INDICATE THAT HE/SHE EXPERIENCED NEGLECT PRIOR TO THE CHAT REFERRAL?

(For example, not getting enough food, not getting needed medical attention, unsafe living conditions)

YES

NO

IF YES, how many times did the child indicate it ever happened?

_____ One time/not often

_____ A few times/occasionally

_____ More than a few times/often

_____ PLEASE CHECK HERE IF THIS AREA WAS NEVER DISCUSSED WITH THE CHILD

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6. BASED ON YOUR CLINICAL JUDGMENT, DO YOU BELIEVE THIS CHILD WAS BEING NEGLECTED AT ANY TIME PRIOR TO THE INITIAL CHAT REFERRAL?

YES

NO

DON'T KNOW

IF YES, who do you think the perpetrator(s) of the neglect was (please indicate relationship to child):

IF YES, how often do you think the neglect occurred?

_____ One time/not often

_____ A few times/occasionally

_____ More than a few times/often

7. DID THE CHILD INDICATE THAT HE/SHE EXPERIENCED BEING ABDUCTED PRIOR TO THE CHAT REFERRAL?

(This can mean being taken by a non-custodial parent, other family member who does not have custody, or by a stranger)

YES

NO

IF YES, how many times did the child indicate it eve happened?

_____ One time/not often

_____ A few times/occasionally

_____ More than a few times/often

_____ PLEASE CHECK HERE IF THIS AREA WAS NEVER DISCUSSED WITH THE CHILD

8. BASED ON YOUR CLINICAL JUDGMENT, DO YOU BELIEVE THIS CHILD WAS ABDUCTED AT ANY TIME PRIOR TO THE INITIAL CHAT REFERRAL?

YES

NO

DON'T KNOW

IF YES, who do you think the perpetrator(s) was (please indicate relationship to child):

IF YES, how often do you think the child was abducted?

_____ One time/not often

_____ A few times/occasionally

_____ More than a few times/often

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9. DID THE CHILD INDICATE THAT HE/SHE EXPERIENCED SEXUAL ABUSE PRIOR TO THE CHAT REFERRAL?

YES NO

IF YES, how many times did the child indicate it ever happened?

- _____ One time/not often
_____ A few times/occasionally
_____ More than a few times/often

_____ PLEASE CHECK HERE IF THIS AREA WAS NEVER DISCUSSED WITH THE CHILD

10. **BASED ON YOUR CLINICAL JUDGMENT, DO YOU BELIEVE THIS CHILD WAS BEING SEXUALLY ABUSED AT ANY TIME PRIOR TO THE INITIAL CHAT REFERRAL?**

YES NO DON'T KNOW

IF YES, who do you think the perpetrator(s) of the abuse was (please indicate relationship to child):

IF YES, how often do you think the sexual abuse occurred?

- _____ One time/not often
_____ A few times/occasionally
_____ More than a few times/often

11. DID THE CHILD INDICATE THAT HE/SHE WITNESSED SEEING ONE PARENT/ CAREGIVER PHYSICALLY OR PSYCHOLOGICALLY ABUSED BY THE OTHER PARENT/ CAREGIVER PRIOR TO THE CHAT REFERRAL? (WITNESSING DOMESTIC VIOLENCE)

YES NO

IF YES, how many times did the child indicate it ever happened?

- _____ Only once/not often
_____ A few times/occasionally
_____ More than a few times/often

_____ PLEASE CHECK HERE IF THIS AREA WAS NEVER DISCUSSED WITH THE CHILD

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12. BASED ON YOUR CLINICAL JUDGMENT, DO YOU BELIEVE THIS CHILD WITNESSED DOMESTIC VIOLENCE AT ANY TIME PRIOR TO THE INITIAL CHAT REFERRAL?

YES

NO

DON'T KNOW

IF YES, who do you think the perpetrator(s) of the domestic violence was (please indicate relationship to child):

Who do you think the victim of the domestic violence was besides the child (please indicate relationship to child):

IF YES, how often do you think the child witnessed domestic violence?

_____ One time/not often

_____ A few times/occasionally

_____ More than a few times/often

13. DID THE CHILD INDICATE THAT HE/SHE EXPERIENCED PEER PRESSURE BASED ON KNOWLEDGE OR PARTICIPATION IN ILLEGAL OR DELINQUENT ACTIVITY?

(For example, pressure to conceal knowledge of illegal or delinquent activity committed by friends or family)

YES

NO

IF YES, how many times did the child indicate it ever happened?

_____ One time/not often

_____ A few times/occasionally

_____ More than a few times/often

_____ PLEASE CHECK HERE IF THIS AREA WAS NEVER DISCUSSED WITH THE CHILD

14. BASED ON YOUR CLINICAL JUDGMENT, DO YOU BELIEVE THIS CHILD EXPERIENCED PEER PRESSURE BASED ON KNOWLEDGE OR PARTICIPATION IN ILLEGAL OR DELINQUENT ACTIVITY AT ANY TIME PRIOR TO THE INITIAL CHAT REFERRAL?

YES

NO

DON'T KNOW

IF YES, how often do you think the child experienced this type of peer pressure?

_____ One time/not often

_____ A few times/occasionally

_____ More than a few times/often

IF YES, do you think this peer pressure was linked to intergenerational involvement?

YES

NO

DON'T KNOW

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IF YES, what relationship to the child did those involved have?

15. DID THE CHILD INDICATE THAT HE/SHE WITNESSED COMMUNITY VIOLENCE PRIOR TO THE CHAT REFERRAL?

(For example, shootings in the child's neighborhood, police activity, threatening environment while walking to/from school, gang affiliation, pressure to join a gang, etc.)

YES NO

IF YES, how many times did the child indicate it ever happened?

_____ One time/not often
_____ A few times/occasionally
_____ More than a few times/often

_____ PLEASE CHECK HERE IF THIS AREA WAS NEVER DISCUSSED WITH THE CHILD

16. **BASED ON YOUR CLINICAL JUDGMENT, DO YOU BELIEVE THIS CHILD WITNESSED COMMUNITY VIOLENCE AT ANY TIME PRIOR TO THE INITIAL CHAT REFERRAL?**

YES NO DON'T KNOW

IF YES, what types of community violence did the child witness?

IF YES, how often do you think the child witnessed community violence?

_____ One time/not often
_____ A few times/occasionally
_____ More than a few times/often

17. DID THE CHILD INDICATE THAT HE/SHE WITNESSED/EXPERIENCED A PERSONAL TRAUMATIC EVENT (THAT WOULD NOT FALL INTO ONE OF THE ABOVE CATEGORIES)?

(For example, it could be either a personal event, such as a car accident that the child was involved in, or a natural disaster, such as an earthquake)

YES NO

IF YES, how many times did the child indicate it ever happened?

_____ One time/not often
_____ A few times/occasionally
_____ More than a few times/often

_____ PLEASE CHECK HERE IF THIS AREA WAS NEVER DISCUSSED WITH THE CHILD

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**18. BASED ON YOUR CLINICAL JUDGMENT, DO YOU BELIEVE THIS CHILD
WITNESSED/EXPERIENCED A TRAUMATIC EVENT AT ANY TIME PRIOR TO THE INITIAL
CHAT REFERRAL?**

YES

NO

DON'T KNOW

IF YES, what was the event(s)?

IF YES, how often do you think the event(s) occurred?

_____ One time/not often

_____ A few times/occasionally

_____ More than a few times/often

NOTE: What is most important in filling out the information in this group of questions is that an event/type of abuse is listed in only one category. For example, the recent terrorist attacks, if traumatic to the child, could be listed in either the community violence section or the traumatic events section – but for purposes of this evaluation, we ask that you list it in **ONLY** one or the other of the sections. Or in the instance of sexual abuse, this would also be a traumatic event, but if it is listed in the sexual abuse question, we don't want the same type of abuse to be listed again as a traumatic event. However, if the child experienced both witnessing domestic violence and physical abuse, then this would be considered two types of abuse, and would be listed twice (once in witnessing domestic violence and once in physical abuse).

THANK YOU!

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Agency ID _____ Child ID _____ Date Completed _____

CHILD SPECIFIC SERVICE LEVEL DATA FOR FIRST 6 MOS OF SERVICES CHAT PROGRAM EVALUATION

DEMOGRAPHIC DATA:

If CBCL NOT provided, please provide the following for the child:

1. Gender of child:

_____ Male
_____ Female

2. Race/ethnicity of child (select one):

_____ African-American
_____ Asian
_____ Caucasian/White
_____ Latino/a / Hispanic
_____ Native American
_____ Bi-racial or multi-racial
_____ Other

If you would like to describe a more specific racial/ethnic category, please provide this information here:

3. Date of birth of child: _____

4. Primary Caregiver (please provide relationship to child; provide as many as apply):

5. Occupation of mother/female caregiver:

6. Occupation of father/male caregiver:

NOTE: IF A CBCL OR YSR HAS BEEN COMPLETED AND THE ABOVE INFORMATION HAS BEEN PROVIDED, YOU DO NOT HAVE TO DUPLICATE IT HERE.

7. _____ Penal Code (PC) or Welfare & Institutions (WIC) Code for instance of abuse/crime that brought child to therapy, if known

8. Language spoken most often in the home (choose one):

_____ English
_____ Spanish
_____ Other; please indicate: _____

9. Is child bilingual? YES NO

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CHAT SERVICE-LEVEL DATA:

1. Who referred the child/family to CHAT: _____

(Please indicate the type of agency and/or relationship to child; e.g., child's elementary school, the CPS social worker, parent self-referred, etc., and NOT the name of a person)

2. Date family contacted your CHAT program _____

3. Victim compensation form filed on child's behalf? YES NO

4. Date victim compensation filed _____

5. Was victim compensation funding approved for this child? YES NO UNKNOWN

6. Types of services provided, per VOCA service definitions, to child
(PLEASE PUT EACH CONTACT WITH THE CHILD IN ONLY ONE CATEGORY)

_____ Number of individual therapy sessions with child in 6 mos
(VOCA therapy or crisis counseling in Progress Reports)

_____ Number of family therapy sessions with child/child's family in 6 mos
(VOCA therapy or crisis counseling in Progress Reports)

_____ Number of group therapy sessions with child in 6 mos
(VOCA therapy in Progress Reports – refers to youth groups but not family therapy)

_____ Number of group treatment/support sessions in 6 mos
(VOCA group treatment/support in Progress Reports – run by someone other than a therapist)

_____ Number of cultural therapeutic activities provided by agency or referred to child in 6 mos
(Refers to activities such as powwows, classes to learn tribal or language of home country, learning dances, etc.)

_____ Number of personal/family advocacy sessions with child in 6 mos
(VOCA personal advocacy in Progress Reports)

_____ Other services that you think were important for this child; please describe: _____

7. Has child ever participated in cultural activities through your agency (by referral or at your agency)?

YES NO

8. If YES, how often does the child/youth currently participate in cultural activities (either by referral or at your agency)?

_____ Weekly

_____ Monthly

_____ On an annual basis (once a year)

_____ Other; please explain: _____

Appendix B

9. Did child/youth work with the same therapist throughout all individual therapy sessions in this 6 mos period?

YES NO

If NO, how many therapists did child work with in this 6 mos period?_____

10. Location of (most) individual therapy sessions (choose one):

_____ At the agency
_____ At a school site
_____ At the child's home
_____ Other; please describe:_____

11. Language used in most individual therapy sessions (choose one):

_____ English
_____ Spanish
_____ Other; please describe:_____

12. Was another member of the child's family receiving services on a regular basis as a primary client during the first 6 mos of child's treatment at this agency or another agency?

YES NO

If YES, please indicate relationship to child:_____

13. Was another member of the child's family receiving services as a secondary client on a regular basis during the first 6 mos of child's treatment at this agency or another agency:

YES NO

If YES, please indicate relationship to child of secondary client(s):

14. Were criminal justice advocacy services provided to this child/child's family? YES NO

If YES, briefly describe:_____

15. Have individual therapy services been terminated at this time? YES NO

If YES, reason for termination of individual therapy services:

If individual therapy services were terminated, date of termination:_____

Appendix B

Benefit/Cost Information

Please fax, mail, or email your responses by OCTOBER 16TH, 2002 to:

Carrie Petrucci
OCJP Program Evaluation
1130 “K” Street, LL22
Sacramento, CA 95814
Fax: (562) 985-5514 / Email: cpetrucc@csulb.edu

We would like to begin collecting information on non-monetary benefits for the CHAT program at your agency. The costs information we will collect directly from the grant and progress report information. You may either provide this form to other members of your staff or collect their input and include it on your response. PLEASE NOTE – it is not intended that you answer each question for every CHAT child. This form is intended to gather your general impressions based on your experience with CHAT children as a group. Thank you for your participation.

1. What individual-level non-monetary benefits to the child do you see DURING the time that the child is receiving CHAT services? In other words, how do you see children benefiting in ways that cannot be accounted for in monetary terms? How is harm reduced for the child? Please be as specific as you can.

EXAMPLE:

Child's attitude has improved. (TOO GENERAL)

Child's attitude toward school involvement has improved. (SPECIFIC)

2. What individual-level non-monetary benefits to the parent or caregiver do you see DURING the time that the child is receiving CHAT services? In other words, how do you see parents/caregivers benefiting in ways that cannot be accounted for in monetary terms? How is harm reduced for the parent/caregiver? Please be as specific as you can.

EXAMPLE:

Parent/caregiver more cooperative. (TOO GENERAL)

Parent/caregiver more cooperative when bringing the child to appointments.
(SPECIFIC)

3. What non-monetary benefits to the families do you see DURING the time that the child is receiving CHAT services? In other words, how do you see the families benefiting in ways that cannot be accounted for in monetary terms? For example, how is harm reduced for the family? Please be as specific as you can.

Appendix B

4. What non-monetary benefits to the community/society do you see DURING the time that the child is receiving CHAT services? For example, how is harm reduced for the community/society at large?

Appendix C

Table C1. Reliability Analysis of Normed and CHAT Full Baseline (English & Spanish-speaking) Samples.

<i>Scale</i>	<i>CBCL</i>		<i>YSR</i>	
	<i>Normed Sample Alpha</i>	<i>CHAT Alpha (n)</i>	<i>Normed Sample Alpha</i>	<i>CHAT Alpha (n)</i>
<i>Competence Scales</i>	n = 3,210		n = 1,938	
Activities	.69	.62 (815)	.72	.67 (305)
Social	.68	.56 (788)	.55	.47 (292)
School	.63	.50 (736)	--	--
Total Competence	.79	.68 (631)	.75	.70 (279)
<i>Empirically Based</i>				
Anxious/Depressed	.84	.79 (816)	.84	.83 (292)
Withdrawn/Depressed	.80	.77 (846)	.71	.67 (295)
Somatic Complaints	.78	.74 (823)	.80	.80 (295)
Social Problems	.82	.73 (823)	.74	.70 (293)
Thought Problems	.78	.72 (745)	.78	.74 (284)
Attention Problems	.86	.77 (841)	.79	.71 (302)
Rule-breaking Behavior	.85	.75 (802)	.81	.75 (297)
Aggressive Behavior	.94	.90 (797)	.86	.86 (287)
Internalizing	.90	.88 (753)	.90	.90 (270)
Externalizing	.94	.91 (743)	.90	.89 (281)
Total Problems	.97	.95 (585)	.95	.95 (235)
<i>DSM-Oriented</i>				
Affective Problems	.82	.75 (815)	.81	.80 (290)
Anxiety Problems	.72	.64 (841)	.67	.64 (293)
Somatic Complaints	.75	.73 (836)	.75	.74 (297)
ADH Problems	.84	.76 (863)	.77	.70 (305)
Oppositional Defiant	.86	.79 (850)	.70	.70 (299)
Conduct Problems	.91	.83 (813)	.83	.81 (296)

Appendix C

Table C2. Reliability Analysis of CBCL Normed and CHAT Spanish-speaking, Latino/a, and English-speaking Samples.

Scale	CBCL			
	Normed Sample Alpha	Spanish- speaking Alpha (n)	Latino/a Alpha (n)	English- speaking Alpha (n)
Competence Scales	n = 3,210			
Activities	.69	.67 (121)	.57 (325)	.58 (305)
Social	.68	.46 (115)	.53 (312)	.59 (287)
School	.63	.40 (115)	.43 (291)	.57 (273)
Total Competence	.79	.66 (92)	.62 (247)	.71 (237)
Empirically Based				
Anxious/Depressed	.84	.77 (125)	.78 (325)	.81 (300)
Withdrawn/Depressed	.80	.81 (132)	.76 (337)	.78(309)
Somatic Complaints	.78	.69 (125)	.74 (329)	.74 (302)
Social Problems	.82	.68 (118)	.71 (329)	.76 (300)
Thought Problems	.78	.66 (114)	.71 (303)	.71 (267)
Attention Problems	.86	.77 (124)	.74 (336)	.77(311)
Rule-breaking Behavior	.85	.60 (126)	.71 (328)	.77 (288)
Aggressive Behavior	.94	.88 (119)	.88 (319)	.91 (293)
Internalizing	.90	.87 (112)	.87 (293)	.88 (281)
Externalizing	.94	.89 (112)	.89 (303)	.92 (267)
Total Problems	.97	.95 (80)	.95 (232)	.95 (212)
DSM-Oriented				
Affective Problems	.82	.75 (128)	.74 (332)	.74 (295)
Anxiety Problems	.72	.59 (127)	.61 (336)	.66 (311)
Somatic Complaints	.75	.61 (127)	.75 (333)	.73 (308)
ADH Problems	.84	.75 (135)	.74 (348)	.78 (315)
Oppositional Defiant	.86	.74 (131)	.76 (340)	.82 (314)
Conduct Problems	.91	.76 (122)	.81 (329)	.84 (294)

Appendix C

Table C3. CIS Reliability Analysis.

Item	n	CHAT alpha
All 13 items at intake.	543	.89
Interpersonal relations scale	621	.76
Broad psychopathology	916	.67
School & work	895	.79
Leisure time	897	.74

Table C4. Parenting Questions Reliability Analysis.

Item	n	CHAT alpha
All 9 items at intake	796	.82
All 9 items at 6 months	450	.86

Appendix D

Table D1. Total Expenditures for 45 CHAT Agencies 2001/2002.

Agency Name	Type	Total Grant Award
Total Expenditures 2001/2002		\$9,167,842
Aldea Children and Family Services Napa Valley	Private/non-profit	\$192,879
Bay Area American Indian Council Oakland	American Indian	\$175,000
CARE Children's Counseling Center Santa Rosa	Private/non-profit	\$277,500
Child & Family Guidance Center Northridge	Private/non-profit	\$250,000
Child Abuse Listening & Mediation Santa Barbara	Private/non-profit	\$250,000
Child Abuse Prevention Council of Placer Co. Roseville	Private/non-profit	\$235,002
Child and Family Institute Sacramento	Private/non-profit	\$205,851
Child Haven, Inc. Fairfield	Private/non-profit	\$275,000
Children's Hospital Oakland Oakland	Private/non-profit	\$249,976
Children's Institute International Los Angeles	Private/non-profit	\$214,916
Clinica Sierra Vista La Monte	Private/non-profit	\$193,082
Comprehensive Youth Services Fresno	Private/non-profit	\$202,022
County of Del Norte Victim Witness Crescent City	Government	\$131,232
County of Glenn Human Resource Agency Willow	Government	\$ 84,088
County of Marin District Attorney's Office Marin	Government	\$208,078

Appendix D

Table D1. Total Expenditures for 45 CHAT Agencies 2001/2002.

Agency Name	Type	Total Grant Award
County of Orange FACT Program Santa Ana	Government	\$158,823
Eastern Sierra Family Resource Center Mammoth	Private/non-profit	\$179,672
Family Service Agency of San Mateo County Burlingame	Private/non-profit	\$219,232
Family Service of Western Riverside County Riverside	Private/non-profit	\$203,603
Family Services of Tulare County Visalia	Private/non-profit	\$231,308
Feather River Tribal Health, Inc. Oroville	American Indian	\$129,873
For the Child, Inc. Long Beach	Private/non-profit	\$213,363
Harvest of Wellness Foundation Joshua Tree	Private/non-profit	\$185,018
Home Start, Inc. San Diego	Private/non-profit	\$443,848
Humane Society of Sonoma City	Private/non-profit	\$246,924
Humboldt Dept. of Mental Health Eureka	Government	\$186,876
Indian Child Welfare Consortium Temecula	American Indian	\$175,000
Indian Health Council, Inc. Pauma Valley	American Indian	\$107,077
Interface Children Family Services of Ventura County Camarillo	Private/non-profit	\$211,250
Karuk Tribe of California Inc. Happy Camp	American Indian	\$ 83,114
Marjaree Mason Center, Inc. Fresno	Private/non-profit	\$218,990

Appendix D

Table D1. Total Expenditures for 45 CHAT Agencies 2001/2002.

Agency Name	Type	Total Grant Award
New Directions to Hope Red Bluff	Private/non-profit	\$170,133
New Morning Youth & Family Services Placerville	Private/non-profit	\$318,984
Plumas Rural Services, Inc. Quincy	Private/non-profit	\$ 98,020
Reach Clinical Services, Inc. Grass Valley	Private/non-profit	\$153,453
Regents, UC (CAARE) Sacramento	Government	\$250,000
Shasta County District Attorney Redding	Government	\$189,893
Stand Richmond	Private/non-profit	\$196,299
Sutter Lakeside Community Services Lakeport	Private/non-profit	\$167,911
Two Feathers McKinleyville	American Indian	\$274,105
Valley Community Counseling Services Stockton	Private/non-profit	\$250,000
Women's Crisis Center Salinas	Private/non-profit	\$249,999
Women's Shelter Program San Luis Obispo	Private/non-profit	\$250,000
Youth for Change Paradise	Private/non-profit	\$123,707
Yuba County Victim Witness Assistance Marysville	Government	\$136,741

Appendix E

Table E1. Characteristics of CHAT CBCL 4-18 Sample.¹

Characteristic	CBCL (n = 880)	
	n	%
Gender of Child		
Female	474	54%
Male	406	46%
Race/ethnicity		
Latino/a	353	40%
White	325	37%
Native American	42	5%
Other	33	4%
African-American	26	3%
Pacific Islander	7	1%
Asian	5	.5%
Unknown	89	10%
Age & Gender		
Boys 4-5 yrs old	37	4%
Boys 6-11 yrs old	273	31%
Boys 12-18 yrs old	96	11%
Girls 4-5 yrs old	48	6%
Girls 6-11 yrs old	230	26%
Girls 12-18 yrs old	196	23%
CBCL Filled out by:		
Biological parent	698	79%
Grandparent	38	4%
Adoptive, step-parent	29	3%
Foster parent	28	3%
Unknown	49	6%
Gender of person who filled out CBCL:		
Female	721	82%
Male	112	13%
Unknown	47	5%

¹ The total count of CBCL's received that were useable for analysis was 1,050. This includes 880 instruments at intake (707 instruments from children who had only one CBCL administration at intake and an additional 173 intakes for children who also had a 2nd administration). Another 165 2nd administration CBCL's, and 5 third administration CBCL's were received. The *full baseline sample* refers to the 880 instruments received at intake and serves as the primary sample for analyses unless otherwise noted.

Appendix E

Table E2. Characteristics of CHAT YSR Sample.²

Characteristic	YSR at Intake (n = 314)	
	n	%
<i>Gender of Child</i>		
Female	209	66%
Male	105	34%
<i>Race/ethnicity</i>		
White	139	44%
Latino/a	101	33%
Native American	14	3.5%
Other	11	3.5%
African-American	9	3%
Pacific Islander	2	.6%
Asian	2	.6%
Unknown	36	12%
<i>Grade in school:</i>		
4 th grade	2	1%
5 th or 6 th grade	67	21%
7 th or 8 th grade	106	34%
9 th or 10 th grade	79	25%
11 th or 12 th grade	35	11%
Unknown	20	6%
Not in school, post high school, other	5	2%

² The total count of YSR's received that were useable for analysis was 360. This includes 314 instruments administered at intake (267 instruments from children who had only one YSR administration at intake and an additional 47 intakes for children who also had a 2nd administration), and 46 YSR's administered at 6 months.

Appendix F

Table F1. Occurrence of Type of Abuse per Child and Therapist and Correlates of Abuse (N varies)¹.

Type of abuse	Occurrence of abuse per child and therapist			How often abuse occurred per child and therapist		
	Per child, abuse occurred	Per therapist, abuse occurred	% difference betw. therapist vs. child	Per child, abuse occurred “more than a few times” response % and (n)	Per therapist, abuse occurred “more than a few times” response % and (n)	% difference betw. therapist vs. child
	% YES and (n)	% YES and (n)				
Witness domestic violence	54.2% (438)	63.9% (537)	+9.7%	58.9% (256)	61.3% (321)	+2.4%
Emotional	50.5% (405)	62.2% (514)	+11.7%	60.9% (245)	67.8% (343)	+6.9%
Physical	37.1% (304)	39.3% (326)	+2.2%	52.3% (157)	51.1% (164)	-1.2%
Sexual	23.4% (189)	24.5% (201)	+1.1%	27.4% (49)	33.0% (65)	+5.6%
Neglect	19.7% (160)	30.0% (250)	+10.3%	71.8% (122)	73.2% (183)	+1.4%
Abduction	3.8% (30)	3.8% (31)	+1 case	81.5% (22) ²	80.6% (25) ³	-0.9%
Correlates of abuse	Occurred per child	Occurred per therapist	% difference betw. therapist vs. child	Per child, occurred “more than a few times” response % and (n)	Per therapist, occurred “more than a few times” response % and (n)	% difference betw. therapist vs. child
	% YES and (n)	% YES and (n)				
Peer pressure ⁴	13.0% (103)	14.4% (18.8)	+1.4%	36.2% (38)	41.0% (48)	+4.8%
Community violence	13.2% (105)	13.7% (112)	+0.5%	35.0% (35)	31.5% (35)	-3.5%
Personal tragedy	17.7% (141)	21.0% (172)	+3.3%	57.4% (81) ⁵	53.6% (90) ⁶	-3.8%

¹ Due to missing data, the total N for each type of abuse varies as follows: per the child, witnessing domestic violence (N = 808); emotional (N = 802); physical (N = 819); sexual (N = 806); neglect (N = 814); abduction (N = 800); peer pressure (N = 791); community violence (N = 794); personal tragedy (N = 798); per the therapist, witnessing domestic violence (N = 841); emotional (N = 827); physical (N = 829); sexual (N = 822); neglect (N = 832); abduction (N = 816); peer pressure (N = 822); community violence (N = 817); personal tragedy (N = 819).

² This percentage reflects “one time/not often” because this response category was more conceptually appropriate and most responses occurred within this category.

³ See footnote 2 above.

⁴ Peer pressure was linked to intergenerational involvement in illegal or delinquent activity by the therapist in 16% or 39 cases.

⁵ See footnote 2 above.

⁶ See footnote 2 above.

Appendix G

Table G1. Percent of Full Baseline Sample in Normal, Borderline, and Clinical Categories at Intake for CBCL 4-18.

Scale	At Intake (n = 880)		
	% normal	% borderline	% clinical
<i>Internalizing</i>	46.4	12.0	41.6
Anxious/Depressed	67.3	15.0	17.7
Withdrawn/Depressed	65.9	18.1	16.0
Somatic Complaints	76.3	10.6	13.2
<i>Externalizing</i>	44.3	13.1	42.6
Rule-breaking behavior	71.7	13.2	15.1
Aggressive behavior	57.3	18.6	24.1
<i>Other</i>			
Social Problems	70.1	14.0	15.9
Thought Problems	74.2	10.7	15.1
Attention Problems	83.3	9.5	7.2
<i>Total Problems</i>	43.0	13.8	43.3
<i>Competencies</i>			
Activities	68.9	14.7	16.5
Social	60.9	18.2	20.9
School	80.2	7.3	12.5
Total Competencies	48.9	10.6	40.6
<i>DSM-Oriented</i>			
Affective Problems	59.7	17.4	23.0
Anxiety Problems	68.8	13.0	18.3
Somatic Problems	77.7	9.3	13.0
Attention Deficit/Hyperactivity	87.3	8.1	4.7
Oppositional Defiant	63.3	14.5	22.2
Conduct Problems	62.0	16.4	21.6

Appendix H

Table H1. Percent of Full Baseline Sample in Normal, Borderline, and Clinical Categories at Intake for YSR 11-18.

Scale	At Intake (n = 314)		
	% normal	% borderline	% clinical
<i>Internalizing</i>	56.7	15.3	28.0
Anxious/Depressed	76.1	10.5	13.4
Withdrawn/Depressed	80.6	11.1	8.3
Somatic Complaints	73.9	14.6	11.5
<i>Externalizing</i>	64.0	11.5	24.5
Rule-breaking behavior	83.8	11.1	5.1
Aggressive behavior	73.2	11.1	15.6
<i>Other</i>			
Social Problems	74.5	11.5	14.0
Thought Problems	81.2	8.0	10.8
Attention Problems	86.0	7.0	7.0
<i>Total Problems</i>	55.4	14.0	30.6
<i>Competencies</i>			
Activities	83.8	4.8	11.5
Social	69.1	15.0	15.9
Total Competencies	58.9	13.1	28.0
<i>DSM-Oriented</i>			
Affective Problems	73.9	13.7	12.4
Anxiety Problems	81.8	7.6	10.5
Somatic Problems	73.2	15.0	11.8
Attention	88.5	6.7	4.8
Deficit/Hyperactivity			
Oppositional Defiant	73.6	16.2	10.2
Conduct Problems	78.0	9.2	12.7

Appendix I

Table I-1. CBCL T Scale Scores for CHAT Intakes and Normed Referred & Non-Referred Samples.

	<i>CHAT</i>		<i>CBCL Referred (N = 1,605)</i>		<i>CBCL Non- referred (N = 1,605)</i>	
	Mean	SD	Mean	SD	Mean	SD
Competence						
Activities	(n = 861)					
Boys 4-5	39.8	10.7				
6-11	40.7	11.0	39.9	11.0	49.6	9.1
12-18	42.0	10.4	39.4	9.6	49.6	9.2
Girls 4-5	37.4	8.9				
6-11	43.1	10.6	40.1	10.0	49.5	9.2
12-18	42.2	10.3	38.8	10.7	49.6	9.3
Social	(n = 853)					
Boys 4-5	39.5	9.0				
6-11	38.9	9.6	36.8	9.9	49.8	9.4
12-18	39.8	9.1	37.3	9.5	49.7	9.3
Girls 4-5	37.0	8.8				
6-11	39.8	9.1	37.8	10.1	49.4	9.3
12-18	38.5	9.4	37.9	9.3	49.3	9.4
School	(n = 736)					
Boys 4-5	42.3	6.4				
6-11	41.0	8.9	35.2	8.5	47.7	7.0
12-18	39.7	8.0	35.5	7.5	48.3	6.9
Girls 4-5	42.6	7.6				
6-11	41.9	8.6	37.9	8.7	48.1	7.3
12-18	43.0	8.1	38.3	8.5	50.1	6.3
Total Competence	(n = 709)					
Boys 4-5	36.4	8.7				
6-11	36.6	10.0	34.6	10.1	50.2	9.9
12-18	38.1	9.9	33.7	8.9	50.0	10.0
Girls 4-5	35.4	6.5				
6-11	38.8	9.6	35.4	9.5	49.7	10.1
12-18	37.5	10.0	34.1	10.3	49.7	10.0
Empirically Based Anxious/Depressed	(n = 871)					
Boys 4-5	58.5	7.7				
6-11	60.4	8.8	63.3	10.0	54.1	5.6
12-18	60.1	8.4	62.2	9.9	54.2	6.0
Girls 4-5	56.2	7.4				
6-11	60.4	9.5	61.2	10.4	54.3	5.7
12-18	60.6	10.3	64.1	11.1	54.2	6.1
Withdrawn/Depressed	(n = 871)					
Boys 4-5	60.1	7.0				
6-11	61.4	8.9	64.3	10.1	54.3	5.7
12-18	62.1	10.3	63.9	10.1	55.7	5.6
Girls 4-5	58.1	8.0				
6-11	59.8	8.4	61.8	9.7	54.0	5.2
12-18	61.3	9.5	65.4	10.6	55.2	5.9

Appendix I

Table I-1. CBCL T Scale Scores for CHAT Intakes and Normed Referred & Non-Referred Samples.

	<i>CHAT</i>		<i>CBCL Referred (N = 1,605)</i>		<i>CBCL Non- referred (N = 1,605)</i>	
	Mean	SD	Mean	SD	Mean	SD
Somatic Complaints	(n = 871)					
Boys 4-5	54.86	5.6				
6-11	59.20	8.5	58.8	8.5	53.6	5.4
12-18	57.68	7.4	59.3	9.0	54.2	5.8
Girls 4-5	57.65	7.2				
6-11	58.64	7.9	58.5	8.2	54.1	5.4
12-18	60.19	8.8	62.0	9.9	54.0	5.4
Social Problems	(n = 871)					
Boys 4-5	59.31	6.6				
6-11	59.78	7.8	64.9	9.7	54.4	5.7
12-18	61.5	8.8	64.0	9.7	54.3	6.0
Girls 4-5	56.4	6.5				
6-11	60.2	8.6	62.9	9.9	54.3	5.4
12-18	61.1	8.9	63.8	10.0	54.2	5.9
Thought Problems	(n = 871)					
Boys 4-5	57.22	7.5				
6-11	58.55	8.1	64.0	10.1	54.2	5.5
12-18	59.49	8.6	62.0	9.3	54.3	5.6
Girls 4-5	58.77	10.5				
6-11	58.24	8.2	61.7	10.1	54.1	5.4
12-18	58.86	8.3	63.2	9.1	54.1	5.4
Attention Problems	(n = 871)					
Boys 4-5	55.5	5.6				
6-11	57.3	7.4	67.0	10.8	54.6	5.3
12-18	58.89	8.3	64.3	10.2	55.0	5.5
Girls 4-5	55.04	7.5				
6-11	56.96	7.3	65.0	11.6	55.5	5.3
12-18	57.74	7.0	65.0	10.7	54.4	5.4
Rule-Breaking Behavior	(n = 871)					
Boys 4-5	57.3	7.2				
6-11	60.0	8.4	65.7	9.0	54.5	5.4
12-18	60.3	7.8	64.2	8.4	54.5	5.3
Girls 4-5	56.7	7.6				
6-11	58.3	7.6	64.5	8.8	55.4	5.1
12-18	59.7	7.6	65.0	9.1	54.9	5.5
Aggressive Behavior	(n = 871)					
Boys 4-5	63.8	10.1				
6-11	63.4	10.7	71.3	12.1	54.2	5.8
12-18	64.1	10.2	67.2	12.1	54.5	6.3
Girls 4-5	61.4	12.4				
6-11	61.1	9.8	67.7	13.1	54.1	5.7
12-18	61.3	9.8	65.3	11.8	54.2	6.3

Appendix I

Table I-1. CBCL T Scale Scores for CHAT Intakes and Normed Referred & Non-Referred Samples.

	<i>CHAT</i>		<i>CBCL Referred (N = 1,605)</i>		<i>CBCL Non- referred (N = 1,605)</i>	
	Mean	SD	Mean	SD	Mean	SD
Internalizing	(n = 871)					
Boys 4-5	57.5	9.9				
6-11	60.7	10.5	63.2	10.3	50.1	9.6
12-18	59.7	10.4	62.4	10.1	51.4	9.1
Girls 4-5	55.8	10.3				
6-11	59.7	10.8	60.6	12.2	50.0	9.5
12-18	60.1	11.5	64.5	10.3	51.0	9.1
Externalizing	(n = 871)					
Boys 4-5	61.2	9.2				
6-11	61.5	10.6	68.5	9.7	50.7	9.1
12-18	61.9	10.0	65.6	9.9	51.2	9.1
Girls 4-5	57.4	12.7				
6-11	59.1	10.6	65.7	11.6	51.6	8.2
12-18	59.4	10.6	64.6	10.3	51.2	8.9
Total Problems	(n = 871)					
Boys 4-5	58.7	10.1	67.9	9.4	50.5	9.4
6-11	61.2	10.4	65.4	9.3	51.3	9.0
12-18	61.4	10.1				
Girls 4-5	56.0	12.2	64.5	10.6	51.0	8.8
6-11	59.3	10.7	65.8	9.4	50.9	9.2
12-18	60.3	10.8				
DSM-Oriented Affective Problems	(n = 871)					
Boys 4-5	58.6	7.3				
6-11	61.3	8.4	65.1	9.7	53.9	5.6
12-18	61.7	8.6	64.4	9.2	54.9	5.8
Girls 4-5	58.9	8.1				
6-11	61.7	8.4	63.7	9.9	54.1	5.4
12-18	62.3	10.0	67.3	9.7	55.0	5.8
Anxiety Problems	(n = 871)					
Boys 4-5	59.2	8.4				
6-11	59.3	8.2	61.8	8.5	54.0	5.5
12-18	59.4	7.6	61.4	8.5	54.4	5.7
Girls 4-5	57.8	7.1				
6-11	59.9	8.1	60.4	8.4	54.3	5.4
12-18	58.5	8.1	62.1	8.7	54.0	5.5
Somatic Problems	(n = 863)					
Boys 4-5	53.4	6.2				
6-11	58.5	9.2	58.2	8.8	53.5	5.9
12-18	56.4	7.6	57.8	9.0	53.7	5.9
Girls 4-5	56.2	8.2				
6-11	57.7	8.6	57.8	8.5	53.7	5.8
12-18	58.6	9.2	60.6	10.6	53.7	5.5

Appendix I

Table I-1. CBCL T Scale Scores for CHAT Intakes and Normed Referred & Non-Referred Samples.

	CHAT		CBCL Referred (N = 1,605)		CBCL Non- referred (N = 1,605)	
	Mean	SD	Mean	SD	Mean	SD
ADHD Problems	(n = 871)					
Boys 4-5	53.7	3.8				
6-11	55.6	6.5	65.0	9.4	54.4	5.5
12-18	56.7	7.0	62.4	8.2	54.6	5.2
Girls 4-5	54.7	6.8				
6-11	55.1	6.3	62.8	9.6	55.0	5.3
12-18	56.1	6.3	62.3	8.8	54.4	5.1
Oppositional Defiant Problems	(n = 871)					
Boys 4-5	62.3	8.5				
6-11	61.9	9.1	67.1	8.9	54.7	5.4
12-18	62.2	8.3	64.1	9.1	54.9	6.0
Girls 4-5	59.8	9.3				
6-11	59.8	8.8	64.3	10.0	54.4	5.4
12-18	59.8	8.1	62.8	9.4	54.4	5.7
Conduct Problems	(n = 871)					
Boys 4-5	60.6	8.8				
6-11	62.0	9.2	68.7	10.2	54.4	5.6
12-18	62.3	8.8	66.0	9.6	54.7	5.7
Girls 4-5	59.2	9.9				
6-11	60.0	9.0	67.2	10.6	55.1	5.3
12-18	60.1	8.5	65.6	9.6	54.5	5.9

Appendix J

Table J1. YSR T Scale Scores for YSR Intakes and Normed Referred & Non-Referred Samples.

	<i>CHAT</i>		<i>YSR Referred</i>		<i>YSR Non-referred</i>	
	Mean	SD	Mean	SD	Mean	SD
Competence						
Activities	(n = 310)					
Boys 11-18	43.5	10.5	37.2	10.3	49.2	9.2
Girls 11-18	46.5	11.3	39.3	10.8	49.3	9.3
Social	(n = 303)					
Boys 11-18	42.1	9.0	40.8	9.2	49.7	9.3
Girls 11-18	41.7	9.4	42.0	9.1	49.5	9.3
Total Competence	(n = 289)					
Boys 11-18	40.8	9.5	36.2	9.5	49.7	10.1
Girls 11-18	42.2	10.8	37.4	10.4	49.7	10.0
Empirically Based						
Anxious/Depressed	(n = 306)					
Boys 11-18	56.4	6.9	58.8	9.5	54.3	5.7
Girls 11-18	59.1	9.0	59.1	9.4	54.2	6.0
Withdrawn/Depressed	(n = 306)					
Boys 11-18	57.4	6.7	58.6	8.1	54.3	6.1
Girls 11-18	58.5	7.7	59.8	8.6	54.4	5.9
Somatic Complaints	(n = 306)					
Boys 11-18	57.9	8.5	58.9	9.9	54.3	5.5
Girls 11-18	58.7	8.3	58.7	9.0	54.4	5.8
Social Problems	(n = 306)					
Boys 11-18	58.2	7.4	59.1	8.9	54.4	5.7
Girls 11-18	59.1	8.6	59.0	8.5	54.4	5.8
Thought Problems	(n = 306)					
Boys 11-18	57.4	7.5	58.1	9.0	54.1	5.5
Girls 11-18	57.3	7.1	58.5	8.3	54.4	5.9
Attention Problems	(n = 306)					
Boys 11-18	56.3	8.2	60.2	10.8	54.4	6.3
Girls 11-18	55.9	6.5	59.4	9.8	54.4	5.7
Rule-Breaking Behavior	(n = 306)					
Boys 11-18	56.2	7.5	59.7	8.1	54.0	5.6
Girls 11-18	55.9	6.2	58.8	8.3	54.1	5.5
Aggressive Behavior	(n = 306)					
Boys 11-18	59.4	9.7	61.3	10.2	54.1	5.7
Girls 11-18	58.1	8.2	59.6	9.4	54.4	6.1
Internalizing	(n = 306)					
Boys 11-18	55.3	10.9	57.1	12.2	50.1	9.9
Girls 11-18	57.9	11.0	58.0	11.2	50.0	10.1

Appendix J

Table J1. YSR T Scale Scores for YSR Intakes and Normed Referred & Non-Referred Samples.

	<i>CHAT</i>		<i>YSR Referred</i>		<i>YSR Non-referred</i>	
	Mean	SD	Mean	SD	Mean	SD
Externalizing	(n = 306)					
Boys 11-18	56.2	10.8	59.7	10.7	49.9	9.7
Girls 11-18	55.1	10.3	57.9	11.1	50.2	10.0
Total Problems	(n = 306)					
Boys 11-18	56.3	10.5	58.7	11.7	50.0	9.9
Girls 11-18	56.8	10.6	58.6	10.9	50.0	9.9
DSM-Oriented Affective Problems	(n = 306)					
Boys 11-18	57.0	7.3	59.5	9.2	54.3	5.6
Girls 11-18	59.3	8.5	60.8	9.5	54.3	5.7
Anxiety Problems	(n = 306)					
Boys 11-18	55.9	6.8	57.2	7.9	54.2	5.4
Girls 11-18	56.9	7.2	57.1	7.6	54.2	5.3
Somatic Problems	(n = 305)					
Boys 11-18	57.8	8.9	58.6	9.8	54.1	5.7
Girls 11-18	58.5	8.3	58.4	8.9	54.4	5.9
ADHD Problems	(n = 306)					
Boys 11-18	56.0	6.9	58.8	8.5	54.5	5.4
Girls 11-18	55.0	5.4	58.2	7.8	54.7	5.6
Oppositional Defiant Problems	(n = 306)					
Boys 11-18	57.9	7.6	59.4	8.2	54.2	5.4
Girls 11-18	57.2	7.6	58.8	8.4	54.3	5.7
Conduct Problems	(n = 306)					
Boys 11-18	58.9	9.5	61.5	9.1	54.2	5.6
Girls 11-18	57.0	7.5	58.9	8.8	53.5	5.4

Appendix K

**Table K1. CBCL and YSR Matched T-Scores
(N = 248).**

Scale	Matched Caregiver/Child	
	CBCL T-Score	YSR T-Score
Competence Scales		
Activities	42.3	45.6*
Social	39.6	41.7*
School	41.7	—
Total Competence	38.4	41.9*
Empirically Based		
Anxious/Depressed	60.5	58.0*
Withdrawn/Depressed	62.1	57.8*
Somatic Complaints	59.7	58.0*
Social Problems	61.1	58.6*
Thought Problems	58.6	56.9*
Attention Problems	57.8	55.9*
Rule-breaking Behavior	59.7	56.1*
Aggressive Behavior	62.2	58.5*
Internalizing	60.5	56.6*
Externalizing	60.2	55.6*
Total Problems	60.7	56.4*
DSM-Oriented		
Affective Problems	62.6	58.3*
Anxiety Problems	58.6	56.3*
Somatic Complaints	58.4	57.6
ADHD Problems	56.0	55.3
Oppositional Defiant	60.6	57.5*
Conduct Problems	61.2	57.7*

*Indicates statistically significant differences were found between the matched caregiver and the youth at $p < .01$ using a paired samples t-test. In all cases, youth scores indicated less problems and more competencies than indicated by the caregiver.

Appendix L

Table L1. Change in Child Functioning Measures at Intake and 6 months.

<i>Child Functioning Measurement</i>	<i>n</i>	Intake	6 mos	Change
		Avg. Score (SD)	Avg. Score (SD)	+ (increase) - (decrease)
CGAS	502	58 (12)	63 ¹ (14)	+5 pts (+8%)
GARF	464	59 (14)	63 ² (15)	+4 pts (+7%)
CIS Total Problem Score	218	25 (9)	19 ³ (10)	-7 pts (-26%)
Empathy – responsive to others	491	3.04 (1)	3.05 ⁴ (1)	No change
Empathy – able to take perspective of another	489	2.76 (1)	2.83 (1)	No change
<i>CIS Scales</i>				
Interpersonal relations	261	9.5 (4)	7.7 (4.2)	-1.7 (-18%)
Broad psychopathology	420	8.8 (3)	6.9 (3.3)	-1.9 (-21%)
School & work	425	3.8 (2.2)	2.8 (2.2)	-1 (-26%)
Leisure time	414	3.1 (2)	2.2 (1.8)	-0.9 (-29%)
<i>Clinical Ranges</i>		% (n)	% (n)	Change
CGAS < 61		59% (608)	45% (267)	-13%
Total CIS > 15		84% (458)	62% (202)	-23%

¹ The CGAS scores child functioning on a scale of 0 to 100, with higher scores indicating higher levels of functioning. Difference in mean averages reached statistical significance at $p < .001$. Effect size was .378, which is within the range of a small to moderate effect of the intervention from intake to 6-months.

² The GARF scores child functioning in relationships on a scale of 0 to 100, with higher scores indicating higher levels of functioning. Difference in mean averages reached statistical significance at $p < .001$. Effect size was .281, which is within the range of a small to moderate effect of the intervention from intake to 6-months.

³ The CIS scores child problems in 13 different areas. Higher scores indicate more problems. The 4 scales plus the total score were each lower at 6 months. For all scales, differences in mean averages reached statistical significance at $p < .001$. Effect size was .724, which is in the range of a moderate to large effect of the intervention from intake to 6-months, however, this is a small sample size.

⁴ Both empathy items were measured on a scale of “1” (very slightly) to “5” (extremely). No differences found at intake and 6 months.

Appendix M

Table M1. Item Percent Responses and Scale Averages for CIS at Intake and 6 month Follow-up.

	0 No Problem		1		2 Some Problem		3		4 A very bad problem		Avg Score [*]	
<i>In general, how much of a problem would you say youth has...</i>	% Intake	% 6 mos	% Intake	% 6 mos	% Intake	% 6 mos	% Intake	% 6 mos	% Intake	% 6 mos	Intake (n)	6 mos (n)
<i>Interpersonal Relations</i>											9.6 (621)	7.8 (376)
Getting along with mother	10.9	16.5	18.2	28.9	33.0	30.2	23.0	15.8	14.8	8.6	2.13 (978)	1.71 (557)
Getting along with father	9.9	16.7	17.3	21.2	31.6	28.8	19.2	16.9	22.0	16.4	2.26 (769)	1.95 (438)
Getting along with other adults	20.2	35.2	31.5	32.2	29.2	23.8	14.9	6.4	4.2	2.3	1.51 (969)	1.08 (559)
Getting along with siblings	7.3	14.5	19.7	24.0	37.5	33.1	23.7	19.8	11.8	8.7	2.13 (866)	1.84 (496)
Getting along with other kids	13.2	22.1	30.1	34.6	32.2	27.3	18.2	11.6	6.5	4.3	1.75 (958)	1.41 (560)
<i>Broad Psychopathology</i>											8.8 (916)	6.9 (523)
Getting into trouble	15.8	21.9	16.6	29.4	35.9	30.8	21.4	12.7	10.2	5.1	1.94 (998)	1.50 (565)
Feeling unhappy or sad	1.9	6.3	9.9	26.8	37.8	32.8	33.1	25.0	17.4	9.1	2.54 (972)	2.04 (552)
Feeling nervous or afraid	4.9	10.2	16.2	30.3	40.8	35.3	25.6	19.2	12.5	5.0	2.25 (974)	1.78 (558)
With behavior at home	8.4	14.9	20.2	28.0	34.2	34.8	26.1	15.4	11.2	7.0	2.11 (994)	1.72 (558)
<i>School & Work</i>											3.8 (895)	2.8 (526)
With behavior at school or job	18.1	28.7	17.8	26.3	32.5	27.6	20.8	10.7	10.8	6.7	1.88 (938)	1.40 (551)
With school work	16.0	28.0	18.7	23.7	31.8	26.0	19.8	15.0	13.8	7.3	1.97 (921)	1.50 (535)

^{*} Differences at intake and 6 months on all scales and statistical significance tests are shown in Appendix L. Statistically significant differences found at $p < .001$ between intake and 6 months for all scale scores.

Appendix M

Table M1. Item Percent Responses and Scale Averages for CIS at Intake and 6 month Follow-up.

	0 No Problem		1		2 Some Problem		3		4 A very bad problem		Avg Score*	
<i>In general, how much of a problem would you say youth has...</i>	% Intake	% 6 mos	% Intake	% 6 mos	% Intake	% 6 mos	% Intake	% 6 mos	% Intake	% 6 mos	Intake (n)	6 mos (n)
<i>Use of Leisure Time</i>											3.2	2.2
											(897)	(519)
With having fun	15.3	28.0	27.2	35.7	36.4	25.5	16.3	9.1	4.8	1.8	1.68 (978)	1.21 (561)
Getting involved in activities	25.4	39.6	25.6	26.7	29.0	22.5	13.1	8.0	6.8	3.2	1.50 (913)	1.09 (525)
<i>Total CIS</i>											25.1	19.8
											(543)	(328)

*Differences at intake and 6 months on all scales and statistical significance tests are shown in Appendix L. Statistically significant differences found at $p < .001$ between intake and 6 months for all scale scores.

Appendix N

Table N1. Therapist Responses to Parent/Caregiver Questions at Intake and 6 months and Percent Change in “Yes” Responses.

Question: Do you think the parent...	At Intake				At 6 months				% Change in Yes
	n	Yes	No	DK*	n	Yes	No	DK	
Q1. ...acknowledges reported abuse occurred...	1070	81.8	7.6	10.7	589	83.2	7.0	9.8	+1.4%
Q2. ...recognizes impact of abuse...	1070	62.5	24.3	13.2	589	66.7	21.9	11.4	+4.2%
Q3....is able to talk about abuse...	1066	49.2	30.6	20.3	588	59.9	22.8	17.3	+10.7%[†]
Q3A. ...If YES, can parent talk in supportive way...	806	59.6	19.5	21.0	468	66.2	17.7	16.0	+6.6%
Q4. ...uses child as emotional companion	1066	30.5	47.5	22.0	584	30.1	53.8	16.1	+6.3%[‡]
Q5. ...is willing to access community support...	1071	82.4	8.3	9.2	588	80.3	7.7	12.1	-2.1%
Q6. ...accepts responsibility for role in abuse...	1068	40.6	23.2	36.1	587	42.6	24.4	33.0	+2%
Q7. ...is capable of protecting child...	1068	66.2	10.6	23.2	587	67.1	13.3	19.6	+0.9%
Q8. ...is capable of setting reasonable limits for child...	1065	52.3	25.8	21.9	580	58.4	22.9	18.6	+6.1%[§]

* “Don’t know”.

[†] McNemar’s test for dichotomous (yes/no) responses for a pre-post test was used on all questions to determine if differences were greater than what could be expected by chance.. “Don’t know” responses were eliminated for this analysis. This item reached statistical significance at $p < .001$.

[‡] This item is reverse scored to match other items, so percentage change reflects difference in “no” responses rather than “yes” responses.

[§] Reached statistical significance at $p < .05$.

Appendix O

Table O-1. Ten Clusters of Benefits to Children based on Concept Mapping Analysis.

Cluster 1: School-related

Child interacts positively with classmates.
 Child interacts positively with teachers.
 Child socializes more appropriately at school.
 Child's attitude toward school involvement has improved.
 Child's behavior in school and environment usually improves.
 Improved functioning at school.
 Improvement in grades.
 Academic performance has improved.
 Child concentrates better at school.
 Increase in positive behavior at school.
 Increased cooperation between the child and the teachers.
 Increased teacher satisfaction.
 Not paying attention in class has diminished or disappeared.
 School attendance has improved.

Cluster 2: External Behaviors

Reduced anger.
 Teenager has been able to assert self appropriately with law enforcement.
 Withdrawing from peer interaction diminished or disappeared.
 Acting aggressively with peers has diminished or disappeared.
 Child's dissociative episodes have been reduced.
 Decrease in defiant behavior toward adults.
 Decrease in hyperactivity.
 Decreased sense of isolation.
 Dramatic decrease in behaviors that are sexual in nature.
 Dramatic decrease of sexual content activities inappropriate for age range.
 Frequency of child's aggressive behaviors has been reduced.
 Frequency of child's oppositional behaviors has been reduced.
 Frequency of child's risk-taking behaviors has been reduced.
 Nightmares diminished or disappeared.
 Reduced anxiety.
 Reduced depression.
 Reduction in stress improves child's health.
 Child has verbalized a decreased level of anxiety.
 Child makes more positive affirmations about his/her community.
 Child's post-traumatic symptoms have been reduced.
 Clinging to parents and teachers diminished or disappeared.

Cluster 3: Assistance to Parents/Caregivers:

Therapy allowed parents and children to deal with their feelings.

Cluster 3: Assistance to Parents/Caregivers (cont.)

Added parental involvement in the child's therapeutic recovery.
 Child has increased understanding of family patterns.
 Harm reduced to child by supporting the parent and helping them understand aspects of trauma/grief.

Cluster 4: Accessing Resources

Child able to actively participate/advocate in the criminal justice system.
 Child provided with resources and information.
 Child able to keep in contact with victim advocate and district attorney.
 Harm reduced to child through coordination of appropriate services with the parent, schools, government agencies, and law enforcement.

Cluster 5: Relating to Peers and in Groups

Child acknowledges authority figures as a positive influence.
 Increased cooperation between the child and his/her peers.
 Teenager has been able to resolve conflicts with friends instead of fighting or cutting off friendships.
 Child can express self more as demonstrated in group activities.
 Child has learned to agree upon group norms and conform to them.
 Child able to call on CHAT program for intervention with school or parents.
 Child interacts with others in more positive and less aggressive ways.

Cluster 6: Therapy Process

Needs of child being addressed by being culturally aware.
 Therapeutic role models consistency and predictability.
 Therapeutic role teaches empathy.
 Therapy has addressed the child's immediate emotional needs.
 Child allowed to be creative and imaginative.
 Child allowed to see that not all adults treat him/her abusively.
 Child encouraged to express self by incorporating cultural elements when appropriate.
 Child was helped to work through trauma and grief he/she experienced.
 Child able to express own feelings to therapist.
 Child validated as having appropriate needs.

Cluster 7: Interactions with Parent and Family

Parent able to maintain communication with the child.
 Strengthened familial relationships.
 Teenager has been able to set limits with abusive family members.
 Tense communication between the child and parent alleviated.

Appendix O

Cluster 7: Interactions with Parent and Family (cont).

Child and parent better able to visualize positive growth and recovery for themselves.
Child and parents more willing to conform to the wishes of the other with positive regard.
Child cooperating more with parents.
Child felt an affective bond with the parent.
Child has increased his/her ability to talk about the trauma to parents.
Child has increased positive interactions with family at home.
Child in foster care able to maintain placement longer.
Child is experiencing less conflict with parent at home.
Child responding to appropriate parental communication.
Child's attitude and behavior in the home have improved.
Child's decreased symptoms have decreased stress for parents.
Child able to make significant connections with family outside of treatment.
Dependability of people and activities important for child living in an unstable home situation.
Dramatic decrease in defiant behaviors towards mother.
Harm reduced to child by assisting parents in communication skills, boundary setting, and behavior plans so that they can more appropriately and consistently manage the child.
Improved parental/child relationship.

Cluster 8: Internal Functioning

Child has been able to work on improving self-confidence.
Child has gained an increased belief in a safe, happy future.
Child learned and experienced a safe environment.
Child learned that his/her own perceptions and feelings are valid.
Child learned hope which creates a willingness to keep trying.
Child learned that he/she is valued.
Child more aware of own feelings.
Child able to verbalize thoughts and feelings regarding his/her trauma (perhaps for the first time).

Cluster 9: Skill Development

Child acquired skills to use for conflict resolution.
Child acquired skills to use for relaxation.
Child can set goals to take charge of his/her own healing process.
Child has become more assertive in identifying what he/she needs and wants.
Child has developed leadership skills.
Child has increased understanding of cycle of violence.

Cluster 9: Skill Development (cont.)

Child has learned and experienced specific coping mechanisms on an individualized basis.
Child has learned anxiety management skills.
Child has learned how to make choices.
Child has learned specific stress management techniques.
Child learned anger management techniques.
Child learned healthy ways of expressing self.
Child learned that he/she has strengths and talents.
Child learned how to express own individuality without being fearful.
Child learned increased emotional IQ.
Development of appropriate communication skills.
Development of appropriate coping skills.

Cluster 10: Symptoms Related to Abusive Incident

Increase in child's self-worth.
Increased ability to set boundaries.
Increased sense of emotional security.
Reduced risk of emotional, physical, and psychological harm.
Child better able to function in his/her environment.
Child feels less like the "problem child".
Child has ability to recall traumatic event(s) with reduced emotional reactivity.
Child has been able to express anger about the traumatic event.
Child has been given space to realize what happened in his/her life.
Child has decreased feelings of responsibility for the abuse experience.
Child has decreased feelings of shame for the abuse.
Child has decreased his/her risk for future exposure to trauma.
Child has developed a sense of belongingness.
Child has developed positive and realistic beliefs about self in relation to the traumatic experience.
Child has increased ability to determine a process for trusting adults.
Child has learned to externalize his/her experience of trauma.
Child has ongoing opportunity to move from the victim phase to the survivor phase.
Child makes more positive affirmations about self.
Child's ability to be self-protective has increased.
Child's development has been promoted.
Child's self-esteem was enhanced.